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Elder Law Attorney

A publication of the Elder Law Section
of the New York State Bar Association

Message from the Chair

It is hard to believe my year as Chair is almost half over. As they say, "Time flies when you're having fun!" Congratulations and thank you to Chair-Elect, Joan Robert, for creating an outstanding fall program at our Fall Meeting at the Hotel Thayer in West Point. It was wonderful to see so many new faces and I am happy that so many of you approached me to introduce yourselves and to ask to become involved in our Section. Your participation is most welcome.

Thanks also to Ira Miller and Howard Krooks for their role with respect to the well-attended Advanced Institute that followed the Fall Meeting. This year's Advanced Institute was unique in that it began with a presentation from Charlie Devlin, head of the Office of Guardianship Services, on the revisions to Part 36 Rules of the Chief Judge governing fiduciary appointments. The revised Rules were issued on September 26 by the Administrative Board, which consists of the Presiding Justices of each of the four departments of the Appellate Division and Chief Judge Kaye, in response to the report of the Birnbaum Commission. Charlie presented us with a clear explanation of what appears to be a complicated set of proposed rules.

As I write this message, we await approval of these Rules by the full Court of Appeals. They are expected to be approved largely as written. The new Rules include several major changes. They call for fiduciary compensation to be measured using a calendar year rather than a 12-month period from the date of appointment, so that an appointment in a calendar year for which anticipated compensation would exceed $5,000 will prohibit receipt of another appointment during that year which would result in compensation to exceed $5,000. They also impose a cap on appointments, so that a fiduciary awarded more than $50,000 in total compensation in any one calendar year will be prohibited from receiving any compensated appointments in the next calendar year. They include new secondary appointment rules, which will make our roles as Court-appointed guardians much more complicated. If approved, these Rules will have a significant effect on the future of guardianships and fiduciary appointments.

On a more positive note, I am happy to report our victory in the U.S. District Court for the Northern District of New York in the case of *VerDow v. Sutkowy*. Judge Munson's ruling that irrevocable Medicaid trusts containing limited powers of appointment are valid will allow us to continue to use these asset preservation vehicles to benefit our clients.

Our Section's Strategic Plan was reviewed, revised and approved by our Executive Committee ahead of schedule at our Fall Meeting in West Point.

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We now have a road map to take us into the future. If you would like a copy, please contact our liaison, Terry Scheid at (516) 487-5537 or e-mail her at tscheid@nysba.org. I look forward to implementing our short-term goals during the remainder of my term.

"We must stay connected as a Section to share our wealth of knowledge and experience. Only then can we continue to make a difference in the lives of our clients."

We have already added Vice-Chairs to some of our more active committees in an effort to encourage more member involvement in leadership roles. Under the direction of Joan Robert and Mitchell Rabbino, we have developed guidelines for district delegates to increase their roles in the Section. We have also put together a task force to develop a plan of action for future meetings. Our goal is for meetings to be accessible to all members and to encourage maximum attendance at these exceptional programs. I trust the task force will make recommendations to further these goals. We are also in the process of updating our membership directory and are hoping to add a pictorial directory to our current Web site.

Our next meeting will be our Annual Meeting at the Marriott Marquis in New York City on January 21, 2003. We anticipate another outstanding program chaired by our Treasurer, Howard Krooks. I am told it will include presentations from past Chairs on substantive issues of interest to all of us. I hope you will join us.

As always, I encourage each of you to become involved and am pleased so many of you have already demonstrated your interest. We must stay connected as a Section to share our wealth of knowledge and experience. Only then can we continue to make a difference in the lives of our clients.

Cora Alsante

Did You Know?

Back issues of the *Elder Law Attorney* (2000-2002) are available on the New York State Bar Association Web site.

(www.nysba.org)

Click on "Sections/Committees/ Elder Law Section/ Member Materials/ Elder Law Attorney."

For your convenience there is also a searchable index.
To search, click on "Edit/ Find on this page."

Note: Back issues are available at no charge to Section members only. You must be logged in as a member to access back issues. For questions, log in help or to obtain your user name and password, e-mail webmaster@nysba.org or call (518) 463-3200.

Editor's Message

With the drums of war already beating in our battle against terror and war with Iraq becoming more certain, our attention is now focused on the men and women of our Armed Forces. We all know that after the debate has ended, and our military is engaged, we will all rally behind our Armed Forces in their effort to defeat tyranny and terror. Our prayers are with them all.

A strong percentage of my elder law clients have served their country. They truly are part of the "greatest generation." And as they age, and need assistance, we must be familiar with the programs and the benefits to which they may be entitled. The theme of this issue of *Elder Law Attorney* is Veterans Benefits.

Senator Tom Morahan, who serves as Chairman of the Committee on Veterans and Military Affairs, has provided a report on important legislation benefiting veterans and their families.

Assemblyman Steve Levy has also contributed an article which outlines the legislation which was passed in the New York State Assembly this past year concerning veterans. He has also listed proposed legislation which will be considered in the Assembly in the coming session.

Ken and Jeanette Grabie have co-authored an excellent article explaining the benefits of the veterans' facilities located throughout New York State. They point out that although these facilities are generally not without cost to veterans who require long-term care, placement in a veterans' nursing home can be most cost effective, while also providing quality care.

Finally, Wallace Davidow has written an article from his perspective as a WWII veteran and provides an important message to elder law attorneys representing veterans.

"We all know that after the debate has ended, and our military is engaged, we will all rally behind our Armed Forces in their effort to defeat tyranny and terror."

Also of note is an article by Dan Fish reporting on the Connecticut waiver proposal. This is an issue with which we must all become familiar. If the proposal is successful in Connecticut, can New York be far behind?

As always, this edition's NEWS section contains timely and useful articles by some of the most experienced practitioners in our section. Thanks to all of them for their continued commitment.

Please enjoy this edition of *Elder Law Attorney*.

Steven Stern

Request For Articles

If you would like to submit an article, or have an idea for an article, please contact

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Articles should be submitted on a 3 1/2" floppy disk, preferably in WordPerfect or Microsoft Word, along with a printed original and biographical information.

Recent Developments in Veterans Benefits

By Senator Thomas P. Morahan

As the Chairman of the Veterans and Military Affairs Committee, I am very proud of the initiatives made in New York State which benefit our senior veterans. These dedicated men and women served our country and were willing to sacrifice their lives for our freedom. It is because of this dedication that we continue to ensure that they receive the benefits which are due.

When it comes to benefits for senior veterans, the Division of Veterans' Affairs is responsible for providing quality service and advocacy for New York veterans, armed forces members and their dependents and survivors, ensuring they receive benefits granted by law for their service to New York and the nation.

New York State provides its veterans with a variety of benefits, from assistance with education and public employment to exemptions from real property tax (even though care of veterans is primarily a responsibility of the federal government). Each year the legislature introduces bills to enact new benefits, enhance existing benefits, or to recognize exemplary military service.

With regard to the physical well-being of our veterans, New York has enacted many measures to provide health care to aging veterans. The most significant initiative in this area was the establishment of five state Veterans' Homes (the "Homes"). The Homes are skilled nursing facilities owned and operated by the New York State Department of Health. They provide comprehensive care to veterans and certain qualified dependents. The following is a list of the facilities, including the area served and the number of beds in each:

Information on admissions policies, services, etc., can be found at the Web site of the New York State Veterans' Homes (www.nysvets.org) or by calling 1-800-NYS-VETS.

In the Senate Majority, we were recently able to secure $81,081 in the 2002-03 state budget to upgrade and improve the Long Island Veterans' Home at the State University of New York at Stony Brook. As Chairman of the Veterans and Military Affairs Committee, and a fellow veteran, I feel that it is very important to keep our veterans homes throughout New York State open, up to appropriate safety standards, and accessible to our disabled vets.

The facility improvements were proposed by the Long Island State Veterans' Home to the Veterans Administration (VA) under the category of Americans with Disabilities Act (ADA) compliance. Under this proposal, the VA would pay $301,158, which equals 65 percent of the total $463,320 project cost. The Senate funds, combined with matching funds from the Assembly, would make up the remaining 35 percent. The VA was expected to make a decision on this project in November.

An important initiative which I sponsored in the Senate regarding the eligibility of veterans for admission to New York State Veterans' Homes, was recently signed by Governor Pataki. This legislation (S.6839) authorizes any veteran of the armed forces of the United States who served during "peacetime" to be eligible for admission to any New York State Veterans' Home.

Recent trends and future projections clearly indicate a decrease in admissions to the Homes. Demographically, there will be a gap in nursing home census in the coming years due to the decreasing number of wartime veterans from World War II.

Facility Location	Area Served	Number of Beds
Batavia (Genesee County)	Western New York	126
Oxford (Chenango County)	Central New York	242
St. Albans	Jamaica (Queens County) New York City Metro.	250
Montrose	Montrose (Westchester County) Lower Hudson Valley	252
Long Island	SUNY Stony Brook (Suffolk County) Long Island	350

Unless the Homes expand the admissions rules to "peacetime" veterans, of whom there are in excess of 300,000 in the state, the fiscal viability of the Homes will be seriously compromised. In addition, these facilities currently have to turn away peacetime veterans who served honorably and are in need of skilled nursing care provided at Department of Health facilities.

Large numbers of unmarried military veterans and their unmarried surviving spouses on Medicaid in nursing homes throughout New York State are not receiving the $90-per-month federal VA pension to which they are entitled. Since nursing homes play a major role in processing applications for Medicaid, they have the expertise, as well as much of the needed information, to apply for this pension. In a large number of cases, there are no relatives or friends who can help the veterans apply.

It is because of this that I introduced Senate Bill 4023c (S.4023c). The goal of this legislation is to require licensed nursing homes to file applications for the Improved Pension Program on behalf of those veterans who are receiving Medicaid. Clearly the nursing home is the obvious, and often the only, resource available to help them with the application. Unless nursing homes are required to apply for the $90 pension on behalf of the relatively small number of their residents who are potentially eligible for the benefit, thousands of those residents will be denied the $1,080-per-year pension which is their right, born of service to their country. VA pension funds are appropriated by the United States government and paid directly to eligible veterans without the need for any funding from New York State. This legislation is currently in the Senate Rules Committee.

Legislation that would specifically affect senior veterans is currently in the Veterans and Military Affairs Committee. Under consideration are S.3340, sponsored by Senator DeFrancisco (R/C-Syracuse), and S.3207, sponsored by Senator Trunzo (R-Brentwood).

The first of these bills, S.3340, would authorize the conversion of the Syracuse Developmental Center into a state Veterans' Home. The Syracuse Developmental Center (SDC) is a residential support facility located in Syracuse. This facility, which has an estimated value of $84 million, is owned by the state of New York. Its slated closure will allow an easy transition to a state Veterans' Home. This facility is centrally located and accessible to veterans from all parts of the state.

The goal of S.3207 is to obtain parity in the benefits received by veterans in VA facilities, or homes with which the VA has a contract, and the state Veterans' Homes. The Homes represent a substantial commitment by New York State to its citizens who have served in the armed forces of our country. The federal VA substantially subsidizes the care of veterans in VA facilities or in facilities with which the VA has a contract. For example, the average federal per diem for skilled care paid to private nursing homes statewide with which the VA has a contract is between $135 and $200. In contrast, New York State Veterans' Homes receive a federal per diem of $35.37 for skilled nursing home care.

This is a gross inequity in treatment for veterans, and New York State alone cannot afford to give parity to veterans in our state Homes. It is the intent of this legislation to secure from the federal government parity in the benefits for veterans in VA facilities, private facilities with a VA contract, and the state Veterans' Homes.

"Unless nursing homes are required to apply for the $90 pension on behalf of the relatively small number of their residents who are potentially eligible for the benefit, thousands of those residents will be denied the $1,080-per-year pension which is their right, born of service to their country."

In addition to these legislative initiatives, I am the sponsor of S.2329a, which is in the Civil Service and Pensions Committee. I'm currently working on having this legislation reported to the Senate floor for a vote.

The legislation would amend the Retirement and Social Security Law, the Education Law, and the Administrative Code of the City of New York, in relation to supplemental military retirement allowances for members of public retirement systems of the state. This bill intends to provide veterans who have retired from public service in the state with a veterans pension benefit similar to that which active public employees are entitled to receive.

The Veterans Service Credit Law of 2000 permits active public employees who served in the military during specific military conflicts to purchase retirement credit for up to three years of military service.

This is the first opportunity veterans have had to include their military service in their public retirement plan since 1976.

Many Korean veterans were not eligible for that 1976 buy-back law. Vietnam veterans were just entering public service at the time. In the ensuing 24 years, many of these veterans provided years of dedicated public service and retired without the ability to add military credit to their retirement.

"As the Chairman of the Veterans and Military Affairs Committee, I will continue to fight to ensure that persons who served in our nation's armed forces get the benefits, recognition and honor that they deserve."

Current employees now have that ability. It is unfair to ignore the service provided by veterans to our state and country now that active employees can receive this benefit. This bill overcomes that injustice by providing retired veterans with a comparable supplemental military allowance.

Lastly, it is important to note that, in 1984, the legislature revamped the method of granting real property tax deductions to veterans owning real property (Chapter 252, L. 1984). The veterans exemption law is now based on the time and location of service, and the exemption is applied as a percentage of assessed valuation. Veterans who served during wartime, including the Korean and Vietnam wars, are eligible for an exemption equal to 15 percent of their property's assessed valuation. Those who served in combat zones are eligible for an additional 10 percent of their assessed valuation, and a further exemption is authorized for those with service-related disabilities.

In addition to these exemptions, there are more recent exemptions enacted by the legislature. Under a 1996 measure, municipalities are allowed to increase the maximum value level for the alternative exemption (Chapter 477, L. 1996). As of 1998, veterans who are eligible for the alternative real property tax exemption based upon the percentage of their disability need not re-file for it annually (Chapter 433, L. 1998).

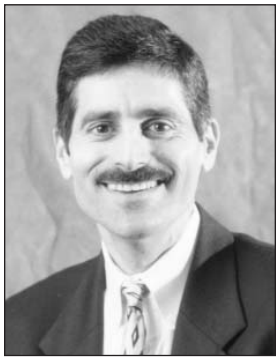
In 1997, the Income Exclusion was created (Chapter 168, L. 1997). This states that veterans disability benefits are excluded from the definition of income for purposes of the senior citizens' real property tax exemption. In 2000, I sponsored legislation (Gold Star Parents) where the legislature authorized an expansion of eligibility for the alternative exemption, at local option, to include a "Gold Star Parent," i.e., the parent of a child who died in the line of duty while serving in the armed forces during a time of war (Chapter 326, L. 2000).

As the Chairman of the Veterans and Military Affairs Committee, I will continue to fight to ensure that persons who served in our nation's armed forces get the benefits, recognition and honor that they deserve.

Senator Thomas P. Morahan is a New York State Senator and represents the 38th District of New York. He is the Chairman of the Veterans and Military Affairs Committee.

Upcoming State Legislation for Veterans

By Assemblyman Steve Levy



Over the past several years, our nation has made a concerted effort to provide to our veterans the recognition they deserve for the indispensable role they played in defending our nation and its freedoms. Books related to the greatest generation pay tribute to those who defeated fascism. Since the fall of the Berlin Wall, greater appreciation is reflected in our tributes to the men who fought in Korea and Vietnam. Our continuing war against terrorism and despots underscores the need to reflect upon those who put their lives on the line in Desert Storm, Afghanistan and the present war against al Qaida.

We, in the state of New York, have an obligation through the legislation we promulgate to ensure that our veterans are properly cared for.

Below is a list of some of the more prominent pieces of legislation that my Assembly colleagues and I passed this year. Please note that any item that became a chapter was signed into law by the Governor. Others will be considered again in the upcoming session in January. Further information regarding these bills can be obtained by logging on to www.assembly.state.ny.us.

Over the course of the last legislative session, my Assembly colleagues and I have passed the following bills affecting veterans:

Temporary State Commission—This bill would provide for the establishment of a temporary state commission to memorialize the 50th anniversary of the Korean War. (A.6065-A; passed Assembly)

Temporary State Commission on Veterans Employment—This bill would create a temporary state commission on veterans employment. (A.7063-A/S.4739-A; **Veto Memo 14**)

Impact on Small Business—This bill would provide financial assistance to small and medium-sized businesses that have been adversely affected by the loss of an owner, manager or key employee who has been called up on active military duty. (A.9630-A; passed Assembly)

Limitation for Phenoxy Herbicide—This law extends the statute of limitation for lawsuits relating to exposure to phenoxy herbicide by armed forces personnel who served in Indo-China for two years. (A.9917/S.6315; **Chapter 88**)

Purple Heart Recipients—The bill would give priority to Purple Heart recipients in the employment by the state of disabled veterans and certify disabled but capable veterans. (A.11268; passed Assembly)

"We, in the state of New York, have an obligation through the legislation we promulgate to ensure that our veterans are properly cared for."

Annuity for Blind Veterans—This bill would provide for annual adjustments in the annuity payable to blind veterans and to surviving spouses of deceased blind veterans. (A.5133-B; passed Assembly/S.4132-C; Rules)

Eligibility Requirements for Veterans Nursing Homes—This bill would change the eligibility requirements for admission to the New York State veterans nursing homes to include those military personnel who served between times of war. (A.11639/S.6839; **Chapter 455**)

During the upcoming legislative session in 2003, I will be continuing my efforts to address issues of importance to veterans. Also, I will be pushing for the passage of my bills in the Assembly that affect our veterans. These bills include:

A.10048—which requires the display of American flags in classrooms, as well as the removal of any member of the board of education or school board that does not provide for the allotment of time for a salute to the flag and a daily pledge of allegiance.

A.9614—which authorizes the Department of Motor Vehicles to issue distinctive "Proud to be an

American" license plates. These plates shall feature an image of the American flag as well as the phrase "Proud to be an American." The charged fee associated with the issuance of these plates shall be made available to veterans organizations and local emergency management organizations for their support.

A.6655—which allows for the voluntary check-off on the state income tax form that would voluntarily contribute any dollar amount to the support of the New York State veterans' homes thereby reducing the amount owed to such an individual.

In addition, the Assembly's Veterans' Affairs Committee will be working on the following issues in the upcoming 2003 legislative session:

1. Hepatitis has historically been associated with military service since military training and combat offer many opportunities for the transmission of blood-borne viral hepatitis through blood-to-blood contact. The committee will be urging the veterans population to be properly tested for Hepatitis C.
2. Many of our surrounding states have established state veterans cemeteries. New York State is investigating the possibility of establishing a state veterans cemetery or cemeteries. The committee has been in contact with the Veterans Administration on this issue.
3. In New York State, woman veterans make up nearly five percent of the total state population of New Yorkers who have served in the armed forces. Two-thirds served during periods of war. The Committee along with the Sub-Committee on Women Veterans will continue to provide education concerning this important segment of the veterans population.
4. There are about 18,000 homeless veterans in New York State. The Committee will continue to help by supporting the most effective programs for homeless veterans, which are community-based, non-profit, vet-helping-vet groups.

Assemblyman Steve Levy represents the 5th Assembly District of New York and is a member of the Assembly's Committee on Aging.

New York State Veterans' Nursing Homes: The Best-Kept Secret in Nursing Home Placement

By Kenneth F. Grabie and Jeanette Grabie

One of the critical functions of any active Elder Law practice is that of assisting seniors and their families with the placement of a loved one into a skilled nursing facility. Generally, this is a time of tremendous stress for the family, a time often magnified by significant pressure from the hospital to quickly discharge the patient. It is therefore critical for the attorney to be aware of all the applicable long term care choices. The New York State Veterans' Nursing Homes are among the possible options and often this option is a community's best-kept secret.

Our clients who are veterans or family members of a veteran do not generally understand that the Veterans Administration (VA) does not authorize or pay for nursing home care for more than six months, except for veterans who require care for service-connected disabilities. A veteran who is discharged from a VA Medical Center may received short-term rehabilitative care at a nursing home, for which the VA will pay up to 100 days under contracts with specific nursing homes. Otherwise, ordinary private pay, Medicare and/or Medicaid rules, and the related traditional planning methods, apply to veterans as they apply to any other nursing home resident.

Nonetheless, an excellent option for veterans and, in some cases, their family members, is placement into one of the five veterans' nursing homes operated by the state of New York which provide a wide range of services to veterans and in some cases, their spouses, children, and other family members. These facilities include the Long Island State Veterans' Home, serving Nassau and Suffolk counties; St. Albans, serving the New York city region; Oxford, serving central New York; Batavia, serving western New York; and Montrose, serving the lower Hudson Valley. The mission of all of these facilities is to provide quality care to all eligible veterans and their eligible dependents in need of skilled nursing care. The facilities vary somewhat in the services they offer and the requirements for admission. However, all provide an excellent quality of care at a relatively affordable cost. As these writers' direct experience has been with the Long Island State Veterans' Home (LISVH), we will begin with that facility.

The LISVH opened in 1991, and is located on 25 acres on the campus of the State University of New York at Stony Brook. The facility has 350 beds, including specialized units for dementia patients and patients suffering from chronic respiratory diseases. The home is certified to accept Medicaid and Medicare payments where applicable. Admission to the home is open to all veterans with more than 30 days active duty, peacetime or wartime, who have been honorably discharged. The private pay rate is $275 per day, less a $53.17 per diem supplement, which veterans are eligible to receive from the VA. This makes the net private pay cost for veterans under $225 per day, which certainly compares favorably with the average private facility rate of well over $325 per day in Nassau and Suffolk counties. The LISVH employs a full-time medical director and a staff of physicians who provide a 24-hour individualized treatment plan for each resident. A comprehensive physical therapy and occupational therapy program is available for long term and sub-acute or rehab residents. Certified Social Workers provide psycho-social services for residents. Therapeutic, recreation and pastoral care are available.

> *"[A]ll provide an excellent quality of care at a relatively affordable cost."*

Spouses of qualified veterans are eligible for admission, provided the veteran is already a resident. If the veteran spouse dies, the surviving spouse may remain for the duration of his or her life.

Additionally, this is the only state veterans' home that offers a medical model day care program. This day care program provides all of the therapeutic and rehabilitative therapies available to residents. Transportation is provided round trip. Importantly, family members of veterans, including spouses, children and parents, among others, are eligible for admission even if the related veteran is deceased. The private pay cost of the day care program is $155. This program qualifies for Community Medicaid as a medical model day care and, where appropriate, may be a perfect opportunity to take advantage of the no-penalty-period rules for transfers allowed under Medicaid rules for Community Medicaid. Further, this time should also be used to engage in long range chronic care Medicaid planning for the applicant in the eventuality that long term care is ultimately required. Patients may be accepted as "Medicaid Pending" on a case-by-case basis. When Community Medicaid is approved, arrangements can be made through the facility for home care services as well. The day care program is available for up to six days a week.

A final note about the LISVH is that it is one of the few nursing homes affiliated with a teaching hospital. As a result of this affiliation, vast medical resources are available to residents and day care participants. In the opinion of the writers, this combination results in a facility that is in the top tier of qualified skilled nursing homes in Nassau and Suffolk counties. The address of the facility is 100 Patriots Road, Stony Brook, New York, 11790, telephone number (631) 444-8500.

Another fine facility is the New York State Veterans' Home at St. Albans, located at 178-50 Linden Boulevard, Jamaica, New York, 11434, telephone number (718) 481-6268. This is a 250-bed facility, including an Alzheimer's unit of 35 beds. Importantly, the home now offers a sub-acute unit of 15 beds, with particular emphasis on short-term rehabilitation. St. Albans has 307 full-time employees. To be eligible for admission, the veteran must have served at least 30 days on active duty, and must have been discharged under honorable conditions. Spouses of ten or more years and parents are also eligible. Recently, the home's admission policy has been expanded to allow the admission of veterans who served during peacetime.

The St. Albans facility provides skilled nursing care, medical, dental, physical and occupational therapy and psychiatric care. Non-medical services include recreational activities, including field trips, religious services, a gift shop and a library. The administrator is accountable to the New York State Department of Health and Governance, a nine-member Board of Visitors representing various veterans organizations. This facility is also Medicaid and Medicare certified.

Western New York is serviced by the New York State Veterans' Home at Batavia, located at 220 Richmond Avenue, Batavia, New York, 14020, telephone number (585) 345-2000. This facility, opened in 1995, has 126 beds and 160 full time employees. Quality nursing care is provided for individuals who require either short term or long term care. This home has several residential cottages with single rooms or double rooms with an adjoining bath. Each cottage has a café for activities and watching television. Erie Cottage has been designed as a specialized dementia unit. This cottage offers a special security system and programming. This particular facility resembles a small village off a central mall. The mall contains the therapy departments, pharmacy, auditorium, dining room, barber and gift shop. Residents are encouraged to participate in the home's operations through a resident council.

The private pay rate for Batavia is $195 per day, with veterans being eligible for the $53.17 supplement from the VA. Upon admission, residents furnish financial data and either pay privately or agree to apply for Medicaid assistance.

The New York State Veterans' Home at Oxford is located at 4211 State Highway 220, Oxford, New York, 13830, telephone number (607) 843-3100. This facility, which serves central New York, has a long history dating back to the 1890s when a Soldiers and Sailors Home was first established in Bath, New York. The current building opened in 1979, and in 1981 its all-new one-story building was opened. Currently, the skilled nursing facility has 242 beds and seven distinctively named units. There are 300 full-time employees. To be eligible, veterans must have served at least 30 days on active duty and be honorably discharged. Spouses and parents are also eligible. However, this facility restricts the admission of spouses to either widows/widowers or spouses of living veterans who are already residents of the facility. Additionally, the Oxford Veterans' Home provides a 24-bed rehabilitation unit, which is geared toward sub-acute or short-term residents. There is also a 38-bed Alzheimer's unit, with services geared toward the needs of veterans with dementia. Oxford has recently added respiratory therapy to its repertoire of services.

Oxford has a notable and elaborate physical therapy department, which employs state-of-the-art equipment to benefit its patients in the areas of physical movement and function. Therapists frequently work with residents who have had strokes, fractures, joint replacement and arthritis. Occupational therapists work closely with residents to increase their ability to perform activities of daily living and independent function. Speech therapists work to improve communication. This facility also provides an ongoing recreation and activities program.

"[E]lder Law attorneys should, at the very least, familiarize themselves with the Veterans' Home in their region in order to adequately counsel their clients and families."

Serving the lower Hudson Valley is the New York State Veterans' Home at Montrose, telephone number (914) 788-6144. This facility, like its sister homes, is certified to accept Medicaid or Medicare. Admission is limited to veterans honorably discharged who entered active duty from New York or were New York residents for at least one year prior to admission, or served at least 30 days on active duty.

This 252-bed facility provides long term skilled nursing care to veterans and their dependents. The physical structure is a one-story design composed of six "Y" shaped units of 42 beds each. Seven "bed pods" in each unit are designed for residents' maximum privacy and convenience. There is a wireless digital nurse calling system. Each resident even has access to one of several private gardens adjacent to the unit. There is a multipurpose room with a full-service deli for residents, staff and visitors and a dramatic 27-foot panoramic 3,200-gallon aquarium.

As the above overview indicates, admission into one of the five State Veteran's Homes for qualified clients offers high quality long term care at affordable rates. These facilities have experience working with Elder Law attorneys, and it is advisable for practitioners to cultivate a relationship with the admission departments. Such homes in an attorney's geographical practice area can be a highly valuable resource. The generally lower private pay rates offer opportunities for greater Medicaid asset protection and planning. Furthermore, Elder Law attorneys should, at the very least, familiarize themselves with the Veterans' Home in their region in order to adequately counsel their clients and families.

Pursuant to new legislation signed by the governor on August 20, 2002, any distinction between wartime and peacetime service has been eliminated and benefits available to spouses and parents of veterans have been expanded.

A significant number of WWII and Korean War veterans (and eventually Vietnam veterans) will be coming to our offices and we must be ready to advise them. Keep in mind that there is no age minimum for an otherwise qualified veteran. Now that the "secret" is out, we hope more of you will utilize these wonderful resources for a significant percentage of your eligible clientele.

Kenneth F. Grabie and Jeanette Grabie are members of the firm of Grabie & Grabie, LLP, located in Smithtown, New York. The firm concentrates its practice in all areas of Elder Law including Medicaid and estate planning, asset protection, guardianship, nursing home placement, wills and trusts, probate and estate matters, and real estate transactions.

Kenneth Grabie is a former New York State Assistant Attorney General representing the Stony Brook Medical Center. He is a member of the Board of Directors of the Suffolk County Bar Association and the Board's liaison to the Elder law Section of the Suffolk Bar. He has served as that bar's Co-Chair of the Elder Law Committee and Legislative Affairs Committee. He is a frequent lecturer on various Elder Law subjects for not-for-profit organizations, community groups, and for the Suffolk Academy of Law. Mr. Grabie is a member of the Legal Advisory Board of the Long Island Alzheimer's Association, a member of the Elder Law and Trusts and Estates sections of the New York State Bar Association, and a member of the National Association of Elder Law Attorneys.

Jeanette Grabie is a summa cum laude graduate of Touro Law Center and a member of the Elder Law and Trusts and Estates sections of the Suffolk County Bar Association, the Elder Law Committee of the New York State Bar Association, and a member of the National Association of Elder Law Attorneys.

Message to Veterans of World War II and Their Elder Law Attorneys

By Wallace F. Davidow

When World War II ended, there were 16,000,000 returning veterans. That's a lot of votes in a nation of 140,000,000. The result was that Congress bent over backwards to please the veterans. Under the GI Bill 2,500,000 veterans were sent to college. Many others were able to buy homes with a four percent guaranteed mortgage. Real estate taxes were reduced for veterans. Congress was generous to veterans.

As it turned out, the 2,500,000 veterans who were sent to college turned our country and the world into a technological society. It was all made possible by the generosity of Congress. All that is now changing. Most of the veterans of World War II have died: there are only 5,000,000 left, and they are dying at the rate of 1,000 per day. Congress now consists of the baby boomers who, in a nation of 240,000,000, are not impressed by World War II veterans. They have consistently lowered the amount of money allotted to the Department of Veterans Affairs (VA). They don't even feel nostalgic about the fact that the surviving veterans of World War II gave years of their youth for their country. Congress recently curtailed the budget of the VA and the contribution to the prescription drug benefits for veterans was reduced. Before, veterans paid $2 per month for each prescription. It was raised to $7 a month per prescription. That's a raise of 250 percent. Nevertheless, it's still a bargain.

Almost every male over 75 served his country in World War II. We did it because our country had been attacked and we had to defend it. The ultimate result was that we preserved our freedom—those of us who survived the war. We also preserved the freedom of the baby boomers who don't always appreciate it.

Many World War II veterans are not aware of the rights that they have under the law. All they have to do is go to the nearest veterans hospital and bring their honorable discharge. They can see a doctor there and tell him or her about the medicines that they are taking. The VA doctor will examine them and determine if these medicines are proper for them. Then they will be able to get their medicine from the VA for $7 a month for each medicine, and they will be required to see the doctor at the VA once a year.

So far as Elder Law is concerned, they should consider irrevocable and revocable trusts for a variety of asset protection reasons and as one of the better ways to transfer wealth to their children upon death. They should also open a safe deposit vault in the name of their children, and make themselves a deputy. Their vault will belong to the children and there will be no contact with the probate court. Their GI life insurance should be assigned to their children as the owners. The probability is that there will be no estate tax in the state where they live unless they have a huge amount of money.

The veterans benefits are somewhat peculiar. The amount of the benefit depends on the amount of money that the veteran was awarded at the end of the war, including the monies paid for his or her college education. The more he or she received, the greater the amount of the exemption from real estate taxes. Of course, a thousand dollar exemption in one taxing district may be little compared to the same thousand dollar exemption in another district. A deduction of $1,000 from a tax of $10,000 may not be too significant, but the same deduction of $1,000 from a tax of $2,000 may be very significant. My advice is to retire to a resort where there are few children. All of the retirement and seasonal homes will contribute to the school expenses, but they won't send any children to school in that district. That keeps the taxes low.

So my advice to World War II veterans is to go to the VA for medical advice, to a resort area to live, and to an Elder Lawyer for advice. My advice to Elder Lawyers is that they should advise their clients to go to the nearest veterans hospital and apply for assistance. The difference in the cost of prescription drugs is staggering. They should also listen carefully to the remembrances of their clients who are veterans. These stories will be lost before long. They are not only history, but human stories of how our freedom was preserved and how the forces of evil were conquered. Elder Lawyers should also inquire and

become familiar with veterans burial benefits. Veterans are entitled to burial in national cemeteries and there is also a contribution by the VA towards the burial. Clients should be encouraged to write to their representatives in Congress and complain about the cutting of the budget of the VA. It is totally reprehensible for Congress to cut that budget. It is not only the combat veterans who risked their lives, but the back-up troops who gave years of their youth in the great effort to beat Hitler before he got the atom bomb, and ultimately to transform Nazi Germany, Fascist Italy, and Imperial Japan into modern friendly, prosperous democracies. The baby boomers got the benefits of all this. They should appreciate it.

Wallace F. Davidow served in the U.S. Army, 1943-1946.

Non-Service-Connected Veterans Benefits for the Elderly and Disabled

By Alice Reiter Feld

One of the best-kept secrets, but an excellent potential source of funds for long term care (either at home or in a facility) for the elderly, is veterans benefits. For those veterans and widow(er)s who are eligible, these benefits can be a blessing for the incapacitated individual who is not yet ready for, or who wants to avoid, a nursing home.

The benefits provided by the Veterans Administration (VA) generally fall into two categories: service-connected and non-service-connected. Statutes regulating veterans benefits can be found in Title 38 of the U.S. Code and the Code of Federal Regulations. In addition, the Veteran's Adjudications Procedures Manual (M21-1) deals specifically with the adjudication of claims for compensation, pension and related benefits within the province of the veterans service center. It applies to all VA regional offices, to include centers with regional office activities, and the VA Records Management Center in St. Louis, Mo.[1]

This article will focus on non-service-connected benefits, since these are the benefits most likely to be available to our clients. These beneifts are called "pension"; this term tends to be confusing because it has nothing to do with years of service, as we normally think of a pension. Instead, it is available to certain **wartime**[2] veterans (or their dependents) who are **totally disabled**[3] because of a non-service-connected condition and who are in **financial need**.[4] (You will also see the program referred to as "improved pension"—this simply applies to the program which came into effect after 1979, in which all assets and income of the veteran are considered for eligibility.) Once the veteran's eligibility requirements are met, a family member may be able to obtain benefits based on his or her status as the veteran's dependent. If the applicant is the widow of the veteran, the applicant must have been validly married to the veteran at the time of the veteran's death. If the widow remarries after the death of the veteran, eligibility is terminated.

Pension is a needs-based program. The veteran's income cannot exceed the maximum annual pension rate (MAPR), which is currently $9,304 per year, or approximately $775 per month. The pension that the veteran is entitled to is the difference between his or her income and the MAPR. Additional dependents add additional amounts to the MAPR.

There is a **specific portion** of the pension program which is of **particular importance** to our clients. This program is entitled "**Aid and Attendance**," and is available to a veteran who is not only disabled, but has the **additional requirement** of needing the aid and attendance of another person in order to avoid the **hazards of his or her daily environment**.[5] As we shall see later, the amount the veteran can receive can be higher, because certain unreimbursed medical expenses are deducted from income to determine the benefit. Under this program, a veteran can receive a maximum of $1,575 per month in benefits, and a widow(er) can receive up to $851 per month. Although the surviving spouse or other dependents may receive the benefit of pension, this article will refer to the recipient of the benefit as the applicant, beneficiary or disabled person.

Service Requirements: A veteran is defined as a person who served in the active military, naval or air services and who was discharged or released under conditions other than dishonorable.[6] In general, to qualify, the veteran must have 90 days or more of active duty under other than dishonorable conditions, one day of which was during wartime.[7]

Disability Requirements: The applicant must be determined to be "permanently and totally disabled." ***THE VA WILL GENERALLY ACCEPT A LETTER FROM THE PERSON'S PERSONAL DOCTOR AS TO THE VETERAN'S DISABILITY***. (This can be filed instead of Form 21-2680.) The letter should state that *the person has an incapacity which requires care or assistance on a regular basis to protect the claimant from the hazards or dangers incident to his or her daily environment*. The applicant does not need to be helpless—he or she need only show that he or she is in need of aid and attendance on a **regular basis**. A patient in an assisted living facility (ALF) is presumed to be in need of aid and attendance. In some states, the facility will have completed a Health Assessment Form which describes the diagnosis and need and is signed by the doctor or nurse practitioner. Get a copy of this form from the ALF.

Net Worth Requirements: The VA will consider the net worth of the applicant and will deny the application if the net worth is such that part of it could be consumed for the applicant's care.[8] As a rule of thumb, the cutoff is $80,000. The home is not counted. In other words, the VA will rarely deny a claim if the net worth is below this number. *There is* ***no penalty period*** *for transfer of assets.* The application simply asks for the net worth of the applicant on the date of the application and does not inquire as to previous transfers.

Income Requirements: The general rule is that even if the applicant fulfills all of the above requirements, the application will be denied if the applicant's countable income exceeds the maximum annual pension rate, which is currently, $1,575 per month. Countable income is all income of any kind attributable to the veteran.[9] **However, in computing the income of the applicant, certain items can be deducted from income. Specifically, unreimbursed medical expenses paid by an applicant may be used to reduce the applicant's income.**[10]

Many items constitute unreimbursed medical expenses. Included in this list are: doctor's fees, dentist, glasses, Medicare deduction, copayments, prescriptions, transportation to doctors, therapy, health insurance and funeral expenses (see below). **Also included in unreimbursed medical expenses are the costs of the ALF or in-home aid.** Obviously, these can make up a big portion of the unreimbursed medical expenses.

A deduction for the medical expenses can only be made if the expense has actually been paid.[11] They must also be *unreimbursed* medical expenses; that is, the beneficiary will receive no reimbursement from insurance of any source. In other words, deductible medical expenses must be out-of-pocket expenses actually paid by the beneficiary.[12] The unreimbursed medical expenses can be incurred by either the beneficiary or a relative of the beneficiary who lives in the same household. This person does not have to be a dependent of the veteran.[13]

Insurance premiums paid by the beneficiary or member of the household are allowable medical expenses.[14] Insurance includes health insurance, including medigap policy premiums, and long term care policies. If a physician directs a beneficiary to take nonprescription drugs, the cost of such over-the-counter medicines is an allowable medical expense deduction.[15] **Mechanical and electronic devices** which compensate for a claimant's or dependent's disabilities are deductible medical expenses to the extent that they represent expenses which would not normally be incurred by nondisabled persons.[16] **Medicare premiums** paid to the Social Security Administration are deductible as medical insurance premiums.[17] The costs of an **adult day care center**, rest home, group home or similar facility or program is an allowable medical expense as long as the facility provides some medical or nursing services for the disabled. The services do not have to be provided by a licensed health care professional.[18] An Alzheimer's day care program would be an example of this.

The costs of **long term care** can, and often will, be the largest unreimbursed medical expense. A medical expense deduction can be allowed for unreimbursed nursing home fees even though the nursing home may not be licensed by the state to provide skilled or intermediate-level care. The definition of a "nursing home" for purposes of the medical expense deduction is not the same as the definition of nursing home set forth in the federal regulations. A nursing home for the purposes of the medical expense deduction is any facility which provides extended-term inpatient medical care.[19]

In-home attendants (i.e., aides) are an allowable medical expense deduction as long as the attendant provides some medical or nursing services for the disabled person. *The attendant does not have to be a licensed health professional. All* reasonable fees paid to the individual for personal care of the disabled person and maintenance of the disabled person's immediate environment may be allowed. This includes such services as cooking and house-cleaning for the disabled person. It is not necessary to distinguish between "medical" and "non-medical" services.[20] For example, the veteran pays an attendant to administer medication and provide for the veteran's personal needs. The attendant also cooks the veteran's meals and cleans house. The entire amount paid to the attendant may be allowed as a deductible medical expense. It makes no difference if the attendant is a licensed health professional.

The cost of an **ALF** and even part, or all, of the cost in an **independent living facility** can be an allowable medical deduction. If the beneficiary is maintained in a home or other institution because the individual needs to live in a protected environment, fees paid to the institution are deductible expenses to the extent that they represent payment for medical treatment.[21] The beneficiary's doctor is your best ally in showing the need for the facility.

Let's do a very simplified example of how this program can help your clients:

Mr. Smith can no longer live at home, but does not need a nursing home. His doctor says he needs to live in an ALF in order to protect himself from the hazards of daily living and because he needs the aid and attendance of another person on a regular basis. His income consists only of Social Security of $950 per month. His assets are $45,000. He would like to move into the Happy Times ALF. The monthly fee for the facility is $2,500.

His income is $950. Subtract the cost of the ALF (an unreimbursed medical expense). The client is in a deficit of $1,550 per month. He is entitled to the maximum benefit of $1,575 per month. This payment is made directly to the veteran.

Another example: Mr. and Mrs. Smith live in the Sunshine Condos. They have income of combined Social Security of $1,400 per month and assets of $48,000. Mr. Smith, a veteran, is in need of an aide in the home because he needs the aid and attendance of another person on a regular basis. The aide costs $500 per week or $2,150 per month. Additionally, Mr. and Mrs. Smith have unreimbursed medical expenses as follows: health insurance—$150 per month; transportation—$50 per month; prescriptions—$700 per month; and funeral payments—$100 per month. Their unreimbursed medical expenses total $3,150. Their income is only $1,400 per month. They have a deficit of $1,750; therefore they would be entitled to the full $1,575 per month.

I suggest that you make a trip to your local VA office and pick up a set of the forms and list of supporting documentation needed (blue sheet) and chat with one of the VA service officers to get some general information. These forms should include: Form 21-526 (Veteran's Application for Compensation or Pension); Form 21-534 (Spouse's application for benefits); and Medical Expense Form 21-8416. This form allows you to amplify the answer on the form (Question 41) regarding unreimbursed medical expenses. A doctor's letter can substitute for Form 21-2680 (Examination for Regular Aid and Attendance). Form 21-4138 (Statement in Support of Claim) is signed by the veteran or agent.

The application is filed at your local VA office. However, in order to establish the earliest possible date, a letter to the VA requesting pension will suffice. It takes approximately two to four months to be approved but is retroactive from the first of the month after the month applied for.

If you would like additional information, I suggest you purchase the Veteran's Benefit Manual, published by Lexis. Also, a good overview is Chapter 14 of Margolis' ElderLaw Portfolio Series (Veteran's Benefits for the Elderly).

I have many clients who are taking advantage of this benefit. Please feel free to contact me if I can further guide you.

Endnotes

1. *Veterans's Adjudications Procedures Manual*, M21-1, § 3.04a [hereinafter "*Manual*"].
2. 38 U.S.C. § 1521j.
3. 38 U.S.C. § 1521a.
4. 38 U.S.C. § 1522, 38 C.F.R. 3.274.
5. 38 U.S.C. § 1502b.
6. 38 U.S.C. § 101(2).
7. 38 U.S.C. § 1521j.
8. *Manual* M21-1, pt. IV, § 16.39e.
9. 38 C.F.R. §§ 3.262, 3.271.
10. *Manual* M21-1, pt. IV, § 16.31.
11. *Manual* M21-1, pt. IV, § 16.31a(1).
12. *Manual* M21-1, pt. IV, § 16.31a(2).
13. *Manual* M21-1, pt. IV, § 16.31a(3).
14. *Manual* M21-1, pt. IV, § 16.31a(4).
15. *Manual* M21-1, pt. IV, § 16.31a(7).
16. *Manual* M21-1, pt. IV, § 16.31a(8).
17. *Manual* M21-1, pt. IV, § 16.31a(9).
18. *Manual* M21-1, pt. IV, § 16.31b(10)(a).
19. *Manual* M21-1, pt. IV, § 16.31b(1).
20. *Manual* M21-1, pt. IV, § 16.31b(2)(a).
21. *Manual* M21-1, pt. IV, § 16.31b(6)(a).

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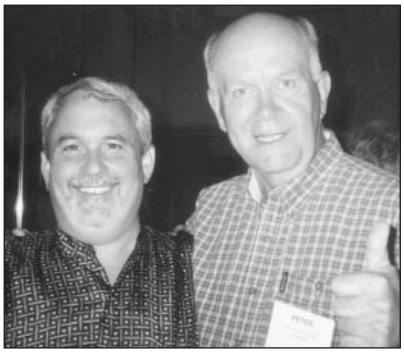
Scenes from the Elder Law Section

Elder Law Attorneys gather at West Point

The Pierro Family

Fall Meeting October 9-11, 2002



Ira Miller and Judge Peter Wells

Fran Pantaleo and Cora Alsante

Hotel Thayer West Point, New York

Kate Madigan, Howard Angione, Ellen Makofsky

René Reixach, Steve Silverberg, Howard Krooks, Neil Rimsky and Ira Miller

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New York Case News

By Judith B. Raskin

We actively solicit receipt of New York cases that you would like to see included in the New York Case News article. Please send your New York cases to Judith B. Raskin, Esq., Raskin & Makofsky, 600 Old Country Road, Suite 444, Garden City, NY 11530.

Capacity

The attorney who prepared decedent's prior will objected to the probate of a subsequent will leaving decedent's estate to his home health aide. *In re Estate of Baldwin*, 91000 (3d Dep't 2002).

Decedent and his wife, with assets of $1.2 million, executed wills in 1990. Their wills left all to each other and on the second death, all to several charities. The couple appointed their attorney, Michael Brockbank, as successor executor. In 1997, with the assistance of a new attorney, the couple changed their wills to omit the charities and appoint their home health aide as 70 percent contingent beneficiary and their new attorney's granddaughter as 30 percent contingent beneficiary. The new attorney was named executor and the aide the successor executor.

Decedent's wife and the new attorney predeceased the decedent. Following decedent's death, the aide was granted letters testamentary in July 1999. In January 2000, Mr. Brockbank reopened the probate and contested the 1997 will. Mr. Brockbank had standing pursuant to SCPA 1410 which states that a person "whose only financial interest (in the estate of the testator) would be in the commissions to which he (or she) would have been entitled if his (or her) appointment as fiduciary were not revoked by a later instrument shall not be entitled to file objections to the probate of such instrument unless authorized by the court for good cause shown." The Surrogate's Court found good cause where an evaluation as part of an Article 81 proceeding that had been brought in March 1997 by Mr. Brockbank raised doubts about the decedent's capacity on August 13, 1997, when the probated will was executed.

The Attorney General and the charities named in the 1990 will were issued citations. The Attorney General and one of the charities appeared and, along with Mr. Brockbank, objected to the 1997 will alleging lack of testamentary capacity, undue influence and fraud.

The Attorney General, the charity and the aide, after discussing settlement without the participation of Mr. Brockbank, then successfully moved to vacate the Surrogate Court's order granting standing to Mr. Brockbank and dismiss his objections to the 1997 will. Mr. Brockbank moved to suspend the petitioner's letters and appoint another executor. His motion was denied but he was awarded attorneys fees to be paid from the estate. Mr. Brockbank and the petitioner appealed.

The Third Department found that although Mr. Brockbank had a legal duty to see that the decedent's wishes were carried out, the Attorney General and the charity would sufficiently represent that interest. The Court found that the attorneys fees were properly awarded to Mr. Brockbank. He provided an "invaluable service" and "substantial benefit to the charitable beneficiaries."

Medicaid

Petitioner, pursuant to Article 78, appealed from a fair hearing decision that her failure to exercise a general power of appointment to herself over funds in an irrevocable trust is a transfer of assets. Appeal denied. *Ferrugia v. NYS Dep't of Health*, 22643 (Sup. Ct., Chautauqua Co. 2002).

Martha Ferrugia created an irrevocable trust in 1987. The trustees were directed to provide her with trust income and principal sufficient to maintain her standard of living and to terminate the trust if she entered a nursing home. The trust agreement gave Ms. Ferrugia a general power of appointment. This "trigger trust" (no longer allowed in New York under EPTL 7-3.1) was valid because it was executed prior to 1992.

Martha Ferrugia subsequently entered a nursing home at which time the trust terminated and she sought Medical Assistance. At a fair hearing, the NYS Department of Health upheld the Chautauqua County DSS determination that the applicant's failure to exercise her general power of appointment to herself was a transfer of assets making her ineligible for medical assistance for 48.5 months. Martha Ferrugia appealed in this Article 78 proceeding.

The court upheld the fair hearing decision because it was not irrational or unreasonable. Ms. Ferrugia argued that the intent of the trust was to

preserve the assets as evidenced by the provisions to terminate on nursing home entry and to grant her a general power of appointment. The court rejected her argument, finding that regardless of her intent at the time, the plain language of the trust was very clear. The court also rejected the petitioner's argument that if the fair hearing decision stands, she would be subjected to a double penalty because she incurred a period of ineligibility when she transferred the funds into the trust. But the court said that since she never applied for Medicaid at the time of the funding, no penalty was assessed at that time. Additionally, Ms. Ferrugia unsuccessfully argued that she would suffer a hardship should the decision stand. The court found that she did not submit any evidence of the three elements required to establish hardship, namely 1) she is otherwise eligible for Medical Assistance, 2) she cannot obtain medical care without Medical Assistance and 3) she has exercised her best efforts to seek return of the transferred assets.

New York City DSS appealed from a Family Court order obligating an institutionalized spouse receiving Medical Assistance to pay child support. Reversed and remitted for new determination of child support. *Lanzi v. Lanzi*, 2001-06571, (2d Dep't 2002).

Alice Lanzi, a community spouse, brought a support proceeding in Family Court pursuant to the Family Court Act, Article 4. NYC DSS objected, arguing that as an institutionalized spouse, Mr. Lanzi had no child support obligations. Mrs. Lanzi was awarded child support for her two minor children from her institutionalized husband's pension and Social Security. DSS appealed.

On appeal, the Court reversed, holding that some support can be awarded from the institutionalized parent's assets but that the Family Court must consider the Social Services Law as well as all other relevant factors. The matter was remitted to reconsider the amount of the support order.

DSS had argued that Social Services Law provides for certain allowances to recipient of Medical Assistance and family but that child support was not included. Additionally, child support does not meet the "exceptional circumstances" requirement for an increased allowance to the community spouse. The court stated that both the allowances under the Social Services Law and the "exceptional circumstances" test do not relate to child support.

The Family Court is directed to consider many factors in determining child support. In *Gomprecht*, the Court of Appeals held that while Family Court is not limited by the Social Services Law, it must consider its provisions. The Family Court must also consider the Family Court Act, section 413, the state's interest and all other relevant factors in the determination of child support.

While medical costs of a parent are not specifically mentioned in the Family Court Act, there is a statutory provision authorizing the Family Court to consider any relevant factors. Educational expenses may be awarded where appropriate under the circumstances and in the best interests of the child. Family Court is not prohibited from issuing an order of child support upon a public assistance recipient.

Judith B. Raskin is a member of the law firm of Raskin & Makofsky, a firm devoted to providing competent and caring legal services in the areas of elder law, trusts and estates, and estate administration.

Judy Raskin maintains membership in the National Academy of Elder Law Attorneys, Inc.; the New York State Bar Association, where she is a member of the Elder Law and Trusts and Estates Law Sections; and the Nassau County Bar Association, where she is a member of the Elder Law, Social Services and Health Advocacy Committee, the Surrogate's Trusts and Estates Committee and the Tax Committee.

Ms. Raskin shares her knowledge with community groups and professional organizations. She has appeared on radio and television and served as a workshop leader and lecturer for the Elder Law Section of the New York State Bar Association as well as for numerous other professional and community groups. Ms. Raskin writes a regular column for the *Elder Law Attorney*, the newsletter of the Elder Law Section of the New York State Bar Association, and is a member of the Legal Committee of the Alzheimer's Association, Long Island Chapter. She is past president of Gerontology Professionals of Long Island, Nassau Chapter.

National Case News:

The Estate Recovery

By Steven M. Ratner

This column addresses recent cases in jurisdictions other than New York. Questions or comments regarding this column should be sent to the author at smr_law@yahoo.com.

Introduction

In *State of Oregon v. John Ashcroft*,[1] the United States District Court for the District of Oregon recently held that Attorney General John Ashcroft could not, by administrative directive, prohibit Oregon physicians from assisting terminally ill patients to commit suicide pursuant to the terms of the Oregon Death with Dignity Act.

The court held that the determination of what constitutes a "legitimate medical practice" rests with the states and that the Attorney General could not invoke the Controlled Substances Act to subvert the will of the Oregon people.

The United States recently appealed this decision to the Ninth Circuit and a decision from that court should be expected in the coming year.

Factual and Procedural Background

Congress enacted the Controlled Substances Act (CSA) as Title II of the Comprehensive Drug Abuse Prevention and Control Act of 1970.[2] The CSA provides a comprehensive federal plan for control and regulation of certain drugs. The congressional findings supporting the CSA disclose that Congress' overreaching concern was preventing drug abuse and illegal trafficking in drugs.

Five schedules of controlled substances are established by the CSA ranging from schedule I drugs (those with no accepted medical use) to schedules II, III, IV and V drugs that may be prescribed subject to the limitations of the CSA. Physicians who prescribe controlled substances must first register with the Attorney General and obtain a DEA certificate of registration. The Attorney General may deny, suspend or revoke a practitioner's registration if the Attorney General determines that such registration would be "inconsistent with the public interest."[3]

The regulations implementing the CSA provide: "A prescription for a controlled substance to be effective must be issued for a *legitimate medical purpose* by an individual practitioner acting in the usual course of his professional practice."[4]

Oregon voters enacted the Oregon Death with Dignity Act in November 1994. The Death with Dignity Act survived both legal challenge in *Lee v. State of Oregon*[5] and a second initiative seeking to repeal the act. The Death with Dignity Act went into effect in October 1997.

The Death with Dignity Act provides a procedure that allows a mentally competent, terminally ill patient to request medication "for the purpose of ending his or her life in a humane and dignified manner."[6] Physicians and pharmacists are immune from both criminal and civil penalties for participating in good faith with the Oregon Act. According to the court, the Oregon Act has been utilized by approximately 70 terminally ill Oregonians since 1997.

In July 1997, Senator Orrin Hatch and Representative Henry Hyde sent a letter to the Administrator of the DEA setting forth an interpretation of the CSA that would have permitted the DEA to revoke the registration of any physician who took actions authorized by Oregon's Act. In October 1997, a second letter was sent to the DEA by Hatch and Hyde that included a memorandum of law setting forth a legal basis for an interpretation of the CSA that would make it a crime to prescribe medication for assisted suicide.

In November 1997, then-DEA Administrator Thomas Constantine wrote Hatch and Hyde expressing an opinion that "delivering, dispensing or prescribing a controlled substance with the intent of assisting a suicide would not be under any current definition a 'legitimate medical purpose.'" In December 1997, Oregon Deputy Attorney General David Schuman, a constitutional scholar and former Professor of Law, University of Oregon, wrote to the Department of Justice urging the Department of Justice to reconsider the DEA's position. After considering Oregon's submission, then-Attorney General Janet Reno responded by stating that the Department of Justice had concluded that the federal government's pursuit of adverse actions against Oregon doctors would be "beyond the purpose of the CSA."

Between 1998 and 2000, Congress failed to pass two legislative attempts to preempt Oregon's Act. On November 6, 2001, Attorney General John Ashcroft issued the so-called "Ashcroft Directive" to DEA Administrator Asa Hutchinson. This directive states in relevant part: "I hereby determine that assisting suicide is not a 'legitimate medical purpose' with the meaning of 21 C.F.R. § 1306.04 (2001), and that prescribing, dispensing, or administering federal controlled substances to assist suicide violates the CSA."

Before publishing this directive, Ashcroft did not consult with Oregon public officials or provide for any public comment.

On November 7, 2001, Oregon commenced an action in federal district court for declaratory and injunctive relief.

The Court's Decision

The district court stated that the central issue in the case was whether the CSA and its implementing regulations permitted Ashcroft to determine that prescribing controlled substances to assist patient suicide is not a "legitimate medical purpose."

The court first reviewed the plain language of the CSA and noted that it is undisputed that under the CSA, the DEA and the Attorney General have broad authority to regulate controlled substances. The court believed, however, that no provision of the CSA demonstrates or even suggests that "Congress intended to delegate to the Attorney General or the DEA the authority to decide, as a matter of national policy, a question of such magnitude as whether physician-assisted suicide constitutes a legitimate medical purpose or practice."

The court next reviewed the legislative history of the CSA and found nothing to suggest that Congress intended the CSA to restrict prescriptions that might be legitimately used under state law to assist suicide or hasten death.

The court concluded its opinion by writing:

> The determination of what constitutes a legitimate medical practice or purpose traditionally has been left to the individual states. State statutes, state medical boards, and state regulations control the practice of medicine. The CSA was never intended, and the USDOJ and DEA were never authorized, to establish a national medical practice or act as a national medical board.

Having ruled in favor of the state of Oregon, the court issued a permanent injunction prohibiting the enforcement of the Ashcroft Directive.

Summary

The author believes that Judge Jones, the author of *Oregon v. Ashcroft*, got it right. The question of whether physicians should assist suicide for terminally ill patients should be left to the people of each state (or perhaps ultimately to Congress). After passing two ballot initiatives, and two challenges in Congress, it was not proper for the Attorney General to undermine the will of the people of Oregon by issuing a directive that was not supported by either the Controlled Substances Act or its regulations. As noted above, the United States has appealed this decision to the Ninth Circuit and a decision from that court should be expected in the coming year.

Endnotes

1. Civ. No. 01-1647-JO (D. Or. 2002).
2. 21 U.S.C. §§ 801-950.
3. 21 U.S.C. § 823(f).
4. 21 C.F.R. § 1306.04.
5. 107 F.3d 1382 (9th Cir. 1997).
6. Or. Rev. Stat. § 127.805(1).

Steven M. Ratner practices elder law in Manhattan. Mr. Ratner is a frequent lecturer and author on issues within his practice areas and is the author of the Elder Law Chapter in the *New York Lawyer's Deskbook*. Steven M. Ratner graduated from the University of Oregon School of Law where he was first in his class, a member of the Order of the Coif, and an Associate Editor of the *Oregon Law Review*. Mr. Ratner received an LL.M. in Taxation from New York University where he was a Student Editor of the *Tax Law Review* and the recipient of the Harry J. Rudnick Memorial Award. Mr. Ratner's work experience includes a one-year clerkship with the Honorable Herbert Y.C. Choy of the United States Court of Appeals for the Ninth Circuit in Honolulu, Hawaii. Mr. Ratner was formerly an Adjunct Professor of Taxation at Golden Gate University in Los Angeles.

Alina Collisson, a second-year law student at Fordham University, assisted with the preparation of this article.

Fair Hearing News

By Ellice Fatoullah and René H. Reixach

We actively solicit receipt of your Fair Hearing decisions. Please share your experiences with the rest of the Elder Law Section and send your Fair Hearing decisions to either Ellice Fatoullah, Esq., at Fatoullah Associates, Two Park Avenue, New York, New York 10016 or René H. Reixach, Esq., at Woods Oviatt Gilman LLP, 700 Crossroads Building, 2 State Street, Rochester, New York 14614. We will publish synopses of as many relevant Fair Hearing decisions as we receive and as is practicable.

In re Appeal of J.C.

Holding

Ellice Fatoullah

The Medicaid program presumes that services provided by children of Medicaid applicants or recipients are intended to be without consideration. However, the presumption may be rebutted. Where the applicant enters into a detailed, arm's length, lifetime personal service contract setting forth the tasks to be performed in return for a lump sum payment, the contract itself is tangible proof that the presumption is rebutted. The Appellant must also show that the services are medically necessary and that the personal care services were actually provided.

Facts

On November 22, 2000, an application for Medicaid was made on behalf of the Appellant. The Appellant was 82 years old, and commenced receiving nursing home services at the Fort Hudson Nursing Home in November 2000.

For the period from October 1999 through May 2000, the Appellant transferred a total of $172,740.89 in resources to his two children, Robert C. and Patti B. Of these resources, $18,430 was returned to the Appellant; thus the Agency determined that the total amount transferred was $154,310.

The major resource transferred was the Appellant's home, which was sold for $140,057.

In October 1999, the Appellant began living with his son, Robert C, in Commack, New York (Suffolk County).

On December 15, 1999, the Appellant entered into a personal care services contract with his son, Robert C., and his daughter, Patti B. Under the terms of the contract, the Appellant agreed to pay his children, as caregivers, the lump sum of $150,000, pending the sale of the house. In the alternative, the Appellant agreed that, if his real property was not sold within 120 days of the contract, he would transfer his interest to his son and daughter, as tenants in common.

René H. Reixach

In January 2000, the Appellant left his son's home and moved in with his daughter, Patti B., in Lake Luzerne, New York (Warren County). The Appellant remained with his daughter until he entered the nursing home in November 2000.

On May 8, 2000, the Appellant's home was sold for $140,057 and the proceeds were deposited into his son's account at the Bank of Smithtown.

By notice dated July 9, 2000, the Agency determined that the Appellant was not eligible under Medicaid for nursing facility services, including waivered home care services, under the Long Term Home Care Program (the "Lombardi program") because the Appellant transferred assets valued at $154,310 for less than fair market value.

On July 23, 2001, a Fair Hearing was requested.

Applicable Law

Sections 360-4.1 and 360-4.8(b) of the N.Y. Comp. Codes R. & Regs. title 18 (N.Y.C.R.R.) provide that a Medicaid applicant or recipient whose available non-exempt resources exceed the resource standards will be ineligible for Medicaid until he or she incurs medical expenses equal to or greater than the excess resources.

Section 366.5(d) of the Social Services Law and 18 N.Y.C.R.R. § 360-4.4 (c)(2) of the regulations govern transfers of assets made by an applicant or recipient or his or her spouse on or after August 11, 1993.

Generally, in determining the Medicaid eligibility of a person receiving nursing facility services, or as a recipient of care, services, or supplies at home pursuant to a waiver under section 1915(c) of the Social Security Act ("waivered services"), any transfer of assets for less than fair market value made by the person or his or her spouse within or after the

"look-back period" will render the person ineligible for nursing facility services.

The "look back period" is the 36-month period immediately preceding the date that a person receiving nursing facility services is both institutionalized and has applied for Medicaid. However, in the case of payments to or from a trust which may be deemed assets transferred by an applicant or recipient, the "look-back period" is a 60-month period instead of the 36-month period. A person is institutionalized if the person is a patient in a nursing facility, or in a medical facility receiving the level of care provided in a nursing facility, or if the person is receiving waivered services.

However, a person will not be ineligible for Medicaid as a result of a transfer of assets under numerous circumstances, relevant here being item (d) that a satisfactory showing is made that: (i) the person or his or her spouse intended to dispose of the asset either at fair market value, or for other valuable consideration; or (ii) the assets was transferred exclusively for a purpose other than to qualify for Medicaid; or (iii) all assets transferred for less than fair market value have been returned to the person. N.Y. Comp. Codes R. & Regs. tit. 18, § 360-4.4(c)(ii)(d).

A transfer for less than fair market value, unless it meets one of the exceptions to the rule, will cause an applicant or recipient to be ineligible for nursing facility services for a period of months equal to the total cumulative uncompensated value of all assets transferred during or after the look-back period, divided by the average cost of care to a private patient for nursing facility services in the region in which such person seeks or receives nursing facility services, on the date the person first applies for Medicaid as an institutionalized person. For purposes of this calculation, the cost of care to a private patient in the region in which the person is seeking or receiving such long-term care will be presumed to be 120 percent of the average Medicaid rate for nursing facility care for the facilities within the region. The average regional rate is updated each January first.

The period of ineligibility begins with the first day of the first month during or after which assets have been transferred for less than fair market value, and which does not occur in any other period of ineligibility under section 360-4.4 (c) of the Regulations for any other prohibited transfer.

Discussion

The Agency's determination is not correct. The uncontroverted evidence establishes that, on May 8, 2000, the Appellant sold his home for $140,057 and the proceeds were deposited into his son's Bank of Smithtown account. It is also established that, on December 15, 1999, the Appellant entered into a personal care services contract with his two children.

The Agency representative contended that the Appellant's application for Medicaid was denied because he transferred resources for less than fair market value, and computed the penalty period at 26.43 months, by dividing the amount of the transfer by the regional nursing home rate for Warren County. She further argued, looking behind the stated words of the personal care contract, what 'really' happened here was a gift from the Appellant to his children, and that the children were acting out of love and affection for their father, thus the transfer was without consideration.

Counsel for the Appellant argued that this was a compensated transfer for fair market value, pursuant to a personal care services contract, between the Appellant and his two children. He argued there is a rebuttable presumption that a transfer to a relative for care provided for free in the past is for less than fair market value. But counsel indicated that the contract rebuts this presumption and is tangible proof that the personal care services were not intended to be provided for free. He further indicated that the contract was an arm's length transaction between the Appellant and his children for valuable consideration. Counsel argued that the children agreed to provide the Appellant a lifetime of care in exchange for the specific compensation spelled out in the contract.

The terms of the contract stipulated that the Appellant's two children would provide the following: room, board, housekeeping, utilities, furnishings, laundry, personal assistance, financial management, and securing health care services. The Appellant agreed to provide his own clothing and personal necessities and reimburse his children for any loss or damage caused by his negligence. The Appellant further agreed to pay his children, as caregivers, the lump sum of $150,000 pending the sale of his real property. In the alternative, the Appellant agreed that, if his real property was not sold within the 120 days of the contract, he would transfer his interest to his son and daughter, as tenants in common. The contract provided that the lump sum from the sale of real property would be applied toward the cost of the personal care services, financial management services and room and board. It specified that the cost of personal care services total $131, 400 per year. This compensation was based on an hourly service rate of $15 per hour, at 24 hours per day, for a year. The contract further provided that the cost of financial management for one year was $21,900 based on $20 per hour, three hours per week, for a year. The contract also charged room and board at $800 per month or $9,600

per year. By its terms, the contract is to remain in full force and effect for the life of the Appellant. Upon his death, no refund would be granted by the caregivers to the Appellant's estate, regardless of the date of death.

Counsel for the Appellant also showed that the going rate for Suffolk County, where he resided at the time of the contract, was $16.75 per hour. Counsel argued that the intent of the parties was clear from the contract that the personal care services were to be provided for compensation by the Appellant. To support his argument, the Appellant cited *Thomas v. Florida Department of Children and Families*, 707 So. 2d 954 (4th Dist. Ct. of Appeals 1998) where the court found that the Applicant for nursing home services paid fair market value for a lifetime personal care services contract between him and his daughter. The Appellant also cited a decision by the Washington State Office of Administrative Hearings, dated November 30, 1996, for the same proposition.

Counsel argued that the Appellant's children provided a full year of 24-hour personal care services under the contract. He also contended that his children continue to visit him in the nursing home and manage his affairs as provided for in the contract. Counsel indicated that the Appellant's son could not attend the hearing due to distance but he provided an affidavit in lieu of appearance. The son indicated that the father required supervision and assistance with all of the activities of daily living, including hygiene, dressing, meal preparation and toileting. He indicated that his father began to wander and became more difficult to handle so that in January 2001, the Appellant went to live with his daughter, Patricia B.

The daughter testified that her father suffers from Alzheimer's Disease and high blood pressure. Ms. Bennett indicated that her father experienced 'sundowning' in the afternoon when his behavior could be aggressive or he would wander. She further testified that the Appellant had his own bedroom and that she prepared his meals, and performed laundry, cleaning and personal hygiene. She testified that her father needed help dressing because he would put on his clothes backwards or wear inappropriate things. Ms. B indicated that she prepared his medications, took him to the doctor, made arrangement for his care and managed his business and financial affairs. She further indicated that she assisted with his nursing home placement and is his advocate. Ms. B. testified that she visits her father three times per week, maintains contact with the staff at the nursing home and attends any meetings concerning his care plan. She indicated that she continues to provide services under the contract for her father by visiting him and managing his business affairs and health care decisions.

Under the Medicaid program, there is a rebuttable presumption that services provided by children are intended to be without compensation. In order to overcome the presumption, the applicant must provide tangible evidence which is acceptable to the Commissioner. *See* 96 ADM 8 p. 12; State Medicaid Manual Transmittal No. 64 3258.1 A.

The issue in this case is whether the personal care services contract between the Appellant and his children constitutes tangible evidence that the services provided by the children were for valuable consideration. A review of the contract submitted by counsel shows that is was in proper form and duly executed by the parties shortly after the Appellant moved in permanently with his son. The contract sets out in detail the rights and responsibilities of the parties and the services to be provided by the caregivers. Further, it clearly indicates the compensation to be provided by the Appellant for the services and calculates the hourly and yearly rate for the 24-hour personal care. By its express terms, the contract clearly shows that the parties intended that the personal care services provided by the children were for compensation. Given the clear intent of the parties and the detailed terms of the contract, the Commissioner found that the Appellant overcame the presumption relied upon by the Agency. The record established that the Appellant intended to compensate his children for the services provided by the personal care contract.

However, the review does not end there. It is unclear from the record whether the caregivers have provided the Appellant with all of the contracted services and earned the compensation claimed. A review of the contract indicates that the caregivers are required to keep records of the services performed. Additionally, some other questions have arisen which need to be addressed. There is no medical documentation from the Appellant's physician showing that he required 24-hour care. Further, the Appellant's son mentioned in his affidavit that the Appellant attended adult day care. It would appear that if the Appellant were attending day care then he did not need care in his home during those hours. Additionally, the record is unclear concerning the Appellant's income and how it was spent. For example, did he use those funds to pay for his room and board under the contract?

Accordingly, the Agency is reversed, and the case is remanded for a new determination of eligibility and to provide the Appellant with an opportunity to submit documentation to show that the caregivers earned the compensation claimed under the contract and the Appellant's need for 24-hour personal care.

Fair Hearing Decision

The Agency's determination that the Appellant was not eligible under Medicaid for nursing facility services, including home waivered services under the Long Term Home Care Program, because the Appellant transferred assets for less than fair market value is not correct and is reversed and remanded. The Agency is directed to make a new determination of eligibility and to provide the Appellant with an opportunity to submit documentation to show that the caregivers earned the compensation claimed under the contract and the Appellant's need for 24-hour personal care.

Editor's Comment

This decision is the first time that a New York lifetime personal care contract between the Medicaid applicant and the children was accepted as an exchange for fair market value. Thus, lump sums may be exchanged for the services provided to the parent by the children so long as the agreement really is an arm's length transaction. In this case, the Appellant showed that the actual cost of the services provided was a little higher than the value stated in the contract.

The decision represents a valuable new—at least in New York State—planning tool for practitioners and our clients.

The Appellant at this Fair Hearing was represented by Steven H. Stern, Esq., Davidow, Davidow, Siegel and Stern, LLP, of Islandia, New York.

Copies of the fair hearing decisions analyzed above may be obtained by visiting the Western New York Law Center, at www.wnylc.com/fairhearingbank.

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René H. Reixach is an attorney in the law firm of Woods Oviatt Gilman LLP, where he is a member of the firm's Health Care Law practice group and responsible for handling all health care issues. He is Chair of the Committee on Insurance for the Elderly of the New York State Bar Association's Elder Law Section. Prior to joining Woods Oviatt, Mr. Reixach was the Executive Director of the Finger Lakes Health Systems Agency. Mr. Reixach authors a monthly health column in the *Rochester Business Journal* and has written for other professional, trade and business publications. He has lectured frequently on health care topics. Mr. Reixach has been an Adjunct Assistant Professor in the Department of Health Science at SUNY Brockport. He also appeared as an expert witness on Medicaid eligibility for the New York State Supreme Court. Mr. Reixach also has served on many advisory committees, including the New York State Department of Health Certificate of Need Reform Advisory Committee and the Community Coalition for Long Term Care. Among Mr. Reixach' s civic and charitable involvements are serving as a Board Member and President of the Foundation of the Monroe County Bar, President of the Greater Upstate Law Project, and a Board Member of the Yale Alumni Corporation of Rochester.

Legislative News

Proposed Legislation Would Clarify Who Can Be Buried at Arlington National Cemetery

By Howard S. Krooks and Steven H. Stern

Howard S. Krooks

Until the Civil War, the nation had no set policy regarding interment of veterans. The massive casualties resulting from that conflict required that the government establish procedures to make and preserve records of deceased soldiers and provide places for their burial. Congress' initial legislation to establish a national cemetery system, the Act of July 17, 1862, section 18, 12 Statutes 594, 596, provided that "the President of the United States shall have the power, whenever in his opinion it shall be expedient, to purchase cemetery grounds and cause them to be securely enclosed, to be used as a national cemetery for the soldiers who shall die in the service of their country."[1] At the conclusion of the war, Congress directed the Secretary of War to engage in a program to find, collect and identify the remains of the war dead. The task was completed in 1870 with the reinterment of nearly 300,000 remains in 73 national cemeteries.

"Restrictive rules for in-ground burial at Arlington were first imposed in 1967."

The grounds of Arlington Mansion, the home of Confederate General Robert E. Lee, were appropriated by the federal government in May 1861, as a fortification to defend Washington, D.C. Arlington National Cemetery was established on the estate on May 13, 1864, as one of the first national cemeteries because burial areas in the other previously designated national cemeteries were rapidly filling. On June 15, 1864, Secretary of War Stanton formally designated Arlington Mansion and the 200 acres surrounding it as a cemetery for the burial of soldiers dying in the vicinity of Washington, D.C.

In 1948, for the first time, Congress codified all previous precedent, practices, and legislation affecting eligibility for burial in national cemeteries. Under the law, four general classifications of persons were accorded the privilege of burial in a national cemetery: (1) those who die while serving honorably in the Armed Forces of the United States, (2) former members of the Armed Forces, (3) citizens of the United States who have served, or may serve, in the armed forces of a Nation allied with the United States during war, and (4) the wife, husband, widow, widower and minor children. At the discretion of the Secretary of the Army, unmarried children generally have been deemed eligible. Adult, unmarried children generally have been deemed eligible if at the time of death they were incapable of self-support by reason of physical or mental condition.

Steven H. Stern

In 1959, Congress expanded burial eligibility to any member of a reserve component of the Armed Forces, the Army and Air National Guard, and the Reserve Officers Training Corps of the Army, Navy and Air Force, whose death occurred under honorable conditions while serving on active duty. It also added the requirement that the Secretary of the Army seek the approval of the Secretary of Defense prior to issuing or amending regulations pertaining to national cemeteries under his jurisdiction.

Restrictive rules for in-ground burial at Arlington were first imposed in 1967. The Secretary of the Army was responding to concerns that the combination of increased interest in Arlington resulting from President Kennedy's burial and an aging veteran population would result in the rapid depletion of burial spaces. From 1962-1966, Arlington's interment rate rose from 4,000 to 7,000 per year. Had the trend continued, the cemetery would have been full by 1968.

The restrictive rules, currently published in federal regulations at 32 C.F.R. 553.15, have remained essentially unchanged since 1967. New proposed legislation (H.R. 4940) would codify eligibility criteria for in-ground burial at Arlington National Cemetery. Eligible persons would be:

a) members of the Armed Forces who die on active duty;

b) retired members of the Armed Forces, including reservists who served on active duty;

c) members or former members of a reserve component who, but for age, would have been eligible for retired pay;

d) members of a reserve component who die in the performance of duty while on active duty training or inactive duty training;

e) former members of the Armed Forces who have been awarded the Medal of Honor, Distinguished Service Cross (Air Force Cross or Navy Cross), Distinguished Service Medal, Silver Star, or Purple Heart;

f) former prisoners of war who die on or after November 30, 1993;

g) the President or any former President;

h) members of the guard or reserves who served on active duty, who are eligible for retirement, but who have not yet retired;

i) the spouse, surviving spouse, minor child and at the discretion of the Superintendent of Arlington, subject to certain requirements, unmarried adult children of a) through h).

The new law would also provide the President with the authority to grant a waiver for burial at Arlington in the case of an individual not otherwise eligible for burial under the military service criteria outlined above but whose acts, service, or contributions to the Armed Forces are so extraordinary as to justify burial at Arlington.

"Interestingly, the bill would eliminate the current practice of granting eligibility to Members of Congress and other high-ranking government officials who are veterans but who do not meet the distinguished military service criteria discussed in the bill summary."

Interestingly, the bill would eliminate the current practice of granting eligibility to Members of Congress and other high-ranking government officials who are veterans but who do not meet the distinguished military service criteria discussed in the bill summary. The bill would also prohibit the consideration of any request for burial in advance of the death of the individual.

Endnote

1. Legislative Summary of H.R. 4940.

Howard S. Krooks is a partner in the law firm of Littman Krooks & Roth PC, with offices in New York City and White Plains. Mr. Krooks devotes substantially all of his professional time to elder law and trusts and estates matters, including representing elderly clients and their families in connection with hospital discharge and nursing home admission issues, preservation of assets, Medicaid, guardianship and related elder law matters. Mr. Krooks is a member of the Executive Committee of the Elder Law Section of the New York State Bar Association, where he serves as the Chair of the Medicaid Committee. Mr. Krooks co-authored a chapter ("Creative Advocacy in Guardianship Setting: Medicaid and Estate Planning including Transfer of Assets, Supplemental Needs Trusts and Protection of Disabled Family Members") included in *Guardianship Practice in New York State*, a book published by the New York State Bar Association. Mr. Krooks has lectured frequently on a variety of elder law topics for the National Academy of Elder Law Attorneys, the National Guardianship Association and the New York State Bar Association. In addition, Mr. Krooks serves as an instructor for the Certified Guardian & Court Evaluator Training: Article 81 of the Mental Hygiene Law program sponsored by The Association of the Bar of the City of New York.

Steven H. Stern is a partner in the law firm of Davidow, Davidow, Siegel and Stern, LLP, with offices in Islandia and Melville, Long Island. Founded in 1913, the firm concentrates solely in the practice areas of elder law, business and estate planning. Mr. Stern is a member of the National Academy of Elder Law Attorneys and is the current Co-Chairman of the Suffolk County Bar Association's Elder Law Committee. He also serves as a member of the Suffolk County Elder Abuse Task Force's Consultation Team. With a strong commitment to educating the local senior community, he is a frequent speaker and published author and also hosts "Seniors Turn to Stern," a radio program on WLUX dedicated to the interests of seniors and their families.

Regulatory News

Social Security Administration Clarifies Treatment of Post Death Expenses Paid from Supplemental Needs Trusts

By Louis W. Pierro and Edward V. Wilcenski

Louis W. Pierro

In the Summer and Winter 2001 editions of the *Elder Law Attorney*, we wrote about changes to the Supplemental Security Income (SSI) rules governing transfers and trusts in the Foster Care Independence Act of 1999 (FCIA).[1] Among the changes in the Act, Congress established transfer penalties for gifts of resources by SSI recipients. Similar to the more-familiar Medicaid program, the SSI program will now impose penalties for uncompensated transfers of resources, and include "exemptions" for certain types of transfers, including transfers to valid First Party Supplemental Needs Trusts established pursuant to 42 U.S.C. § 1396p(d)(4)(A).

Over the past year or so, based on our own experience, as well as the experiences of a number of our colleagues, we have come to the conclusion that the Social Security Administration is having a bit of difficulty applying some of these new rules in a consistent fashion. These inconsistencies have been especially acute in cases involving First Party Supplemental Needs Trusts. In this article we want to highlight one recent effort by the Social Security Administration to clarify one issue that had become the source of particular confusion.

Remember that First Party Supplemental Needs Trusts are those established by a parent, grandparent, guardian or court, funded by an individual who is disabled and under the age of 65, and, most importantly for the purposes of this article, provide that upon the death of the disabled beneficiary the state is reimbursed up to the cost of medical assistance paid during the course of the beneficiary's life.[2] The federal Medicaid provision authorizing the use of these trusts has been in existence since 1993, and as such First Party Supplemental Needs Trusts have been reviewed by the Social Security Administration on behalf of SSI recipients for many years. Because all such trusts are irrevocable and not subject to the control of the disabled beneficiary, they have generally been accepted by the Social Security Administration as exempt for SSI purposes under the general rules governing "availability" under the SSI.[3]

Edward V. Wilcenski

However, after FCIA '99 specifically incorporated the Supplemental Needs Trust provisions of the federal Medicaid statute into the federal SSI,[4] some field and regional offices of the Social Security Administration were interpreting the "payback" provision in the Supplemental Needs Trust statute to preclude *any* payment by the trustee upon the death of the beneficiary prior to satisfaction of the Medicaid lien, notwithstanding well-established state laws that provide for payment of taxes and administration expenses prior to the payment of debts and distribution to the beneficiaries.

In May 2001, the Social Security Administration issued EM (Emergency Memo) 01085, which established the Social Security Administration's policy on trust provisions relating to state Medicaid reimbursement requirements for trusts established pursuant to 42 U.S.C. § 1396p(d)(4)(A). Current Social Security Administration policy is to allow the trust to provide for the following expenses paid from the trust prior to reimbursement to the state upon the death of the beneficiary:

1. Taxes due from the trust to the state and federal government by reason of the death of the beneficiary;
2. Reasonable fees needed to administer the trust, including an accounting and other standard services required upon the termination of a trust.

The following expenses will be *prohibited* from being paid prior to reimbursement to the state:

1. Payments of debts owed to third parties;
2. Funeral expenses;
3. Payments to residuary beneficiaries.

The Transmittal continued on to state that these restrictions apply "upon the death of the beneficiary. Payments of fees and administration expenses during the life of the beneficiary are allowable as permitted by the trust document and are not affected by the state Medicaid reimbursement requirement." The Emergency Transmittal was eventually incorporated into the POMS at SI 01120.203(B)(3)(a) and (b).

While it is certainly beneficial to have an established policy that can be used for drafting trusts in the future, the policy does create some difficulty for many trusts already in existence. Recognizing that the beneficiaries of these trust are limited to less than $2,000 in resources (for SSI recipients) outside of the trust, many trusts were drafted to provide that upon the death of the beneficiary, trust funds should be used to pay the reasonable funeral expenses of the deceased beneficiary. After payment of the funeral expenses, the state would be paid.

As a practical matter, there is nothing in the SSI statute or in the POMS that would preclude a trustee from purchasing an irrevocable funeral contract from trust funds prior to the death of the beneficiary if there is a risk that the beneficiary's other assets would be insufficient to accommodate such an expense, and it is anticipated that the reimbursement to the state will exhaust the balance of the trust. However, this administrative clarification may create some difficulty for existing trusts that provide for funeral payments prior to Medicaid reimbursement in cases where the trusts are reviewed anew, either through recertification, new application, or initial funding. In such a case, it may become necessary to petition a court for reformation of the trust to remove the provision, presuming that the trust does not allow the trustee the power to amend absent court order for the purpose of maintaining eligibility for government benefits.

Finally, this administrative clarification should also put trustees of such trusts at rest that they and their legal representatives will be paid for the efforts that will be required at the time the trust is being terminated.

Endnotes

1. Pub. L. No. 106-169 (1999).
2. 42 U.S.C. § 1396p(d)(4)(A).
3. Program Operations Manual System (POMS) SI 1120.200(D)(2).
4. 42 U.S.C. § 1382b(e)(5).

Louis W. Pierro is a graduate of Lehigh University and Albany Law School of Union University. Mr. Pierro was admitted to the bar in January 1984, and is licensed to practice in all New York state and federal courts. His practice focuses on representing individuals, families and small business owners on estate planning, long-term care planning, estate and trust administration and business succession planning. Mr. Pierro is also a frequent lecturer and author on the topics of estate planning, estate and gift taxation and elder law, and served as adjunct professor at Siena College from 1988-1995. Mr. Pierro is past Chair of the New York State Bar Association Elder Law Section, and past Chair of its Committee on Insurance for the Elderly (1995-1998). He was appointed to serve on the Task Force on Long Term Care Financing, formed by Governor Pataki and legislative leaders to study long-term care issues in New York State. Mr. Pierro also is Vice-Chair of the New York State Bar Association Trusts and Estates Law Section Committee on Estate Planning, and serves as a member of that Section's Executive Committee. Mr. Pierro is a member of the Estate Planning Council of Eastern New York, the National Academy of Elder Law Attorneys and the American Bar Association, Probate and Trust Section. He serves on the Board of Directors of the Capital Area Consortium on Aging and Disability, Senior Services of Albany and McAuley Living Services.

Edward V. Wilcenski, Esq., is a partner in the law firm of Pierro & Associates, LLC. He practices in the areas of estate planning and administration, elder law, and future care planning for persons with disabilities. He is a graduate of Albany Law School of Union University, and received his Bachelor of Science in Economics magna cum laude from Siena College in Loudonville, New York. Mr. Wilcenski is Vice Chair of the New York State Bar Association's Medicaid Committee, a member of the Public Policy Committee of the National Academy of Elder Law Attorneys, and a member of the New York State Bar Association Committee on Persons Under Disability. He is a contributing author to numerous publications on the topics of elder law and future care planning for the New York State Bar Association, including *Guardianship Practice in New York State*, *Planning for Incapacity*, and *Estate and Future Planning for Persons with Developmental Disabilities and Their Families*, and serves on the Board of Directors for numerous local organizations serving the elderly and disabled in the Capital District.

Practice News

Something You Do Not Want—In Your Elder Law Practice!

By Vincent J. Russo

Yes, there is something you do not want and that is **Accounts Receivable**! In fact, you should avoid accounts receivable like the plague. Accounts receivable reflect money that is owed to you for services performed. Does that sound right?

I would love to go to the movies and tell the cashier, "I will pay you on the way out after I see the movie." So, let's analyze what is going on.

ACT ONE: SERVICES TO BE PERFORMED. You are going to perform legal services for a client. You control your environment. You have a written engagement agreement that spells out the scope of your services and your fees. Are you going to perform the services and then ask to get paid at the end? If so, where are you getting the money to pay the rent and staff who will help you do the work?

You get the point. It is a good idea to get a retainer payment up front to help with the cash flow. Sounds like a reasonable request. But, you ask, "What if I request the retainer and the client does not hire me?" If that is the case, what makes you think the client will pay you when you have completed your services?

Many Elder Law attorneys ask for a retainer of one-half of the total fee. Let me back up a second. Most Elder Law attorneys are quoting a fixed fee to implement an estate/long term care plan. The fee would include the meetings, telephone calls and the documents—oh yes, and their advice. For example, if the total fee is $5,000, then the retainer would be $2,500. It is also typical that the engagement agreement provides that the balance be paid once the plan is implemented (i.e., when the documents are signed). The initial retainer must be refunded if the work is not performed.

This approach has reduced the possibility of accounts receivable by one half. This is dramatic, but can you do more?

What one should never do is work on a client matter without an engagement agreement; or if you have one, without an initial retainer. This guarantees accounts receivable. Try collecting your fee from a client who has not authorized you to work on his matter. With an engagement agreement in hand and no payment, you have legal rights, but are you going to sue the senior? Is it worth it? This process is called working for free, also referred to as "unintentional pro bono work," as distinguished from intentional pro bono work. For the fun of it, try telling your spouse about your "unintentional pro bono work"—see what his or her reaction is? Can you guess?

ACT TWO: THE WORK IS DONE. Now, you are with the client at the final meeting, the work is completed and the fee is owed. Most seniors will have the check. They are ready to pay. How can we help them? One suggestion is to give them a letter with a draft of the documents prior to the meeting and include a statement of your services reflecting the balance owed and that payment is due at the meeting. Not often, but sometimes, the client does not have the check. Credit cards! Credit cards! Credit cards! Yes, many people—including seniors—have credit cards. People even enjoy getting the miles! As time goes on, the aging baby boomers will be in your office and your clients will be looking to charge your services. It is well worth the credit card charge to offer this option. Since we made credit card charges available, our accounts receivable have dropped by more than 25 percent.

ACT THREE: THE BALL IS IN YOUR COURT. So, let's move on. You have finished the work and the client has not paid you in full. The ball is now in your court. Make sure that you give clients a bill before they leave the office. Give them a self-addressed return envelope, which is also stamped. Get them to commit as to when the check will be sent or when they will call in their credit card number. The amount owed is now an "accounts receivable."

The next step is to have a procedure on how you are going to collect the accounts receivable. What will you do next? After so many days, a past-due notice should be sent out. We send out a past-due notice after 15 days. If that notice is ignored, then we follow up with a phone call on day 30. We have assigned one person in our office to follow up requesting payment of the accounts receivable. In a small office, it might be your bookkeeper, office manager or your assistant. I do not suggest that the attorney who rendered the services be involved in the collection process during this stage. This will allow you to remain professional and allow time to resolve the situation (for example, you may feel pressured to react to a client on the telephone).

Depending upon the response from the client, the attorney will have to review the situation and make a

decision regarding the next step. If the client does not have the financial means to pay, then you may want to work out a payment schedule. I am not a big fan of this approach. If you use it, keep the time frame short with a minimum number of payments. Otherwise, you can spend more time and effort than the amount you collect: a bookkeeper's nightmare! The client does not want to pay because he or she is unhappy with you and/or your services. Take a deep breath, be honest with yourself, put yourself in the client's shoes, and then make a decision to either compromise the fee or write it off. If you compromise the fee, make every effort to get paid immediately as opposed to a payment schedule. Your chances of collecting this money will be greater. Let's say the client thinks you have been negligent in the handling of his or her matter or suggests malpractice, what do you do next? In most cases, my approach is to write off the fee, even if I know I am right. The negative result created by my attempts to collect the fee will likely be fruitless and may lead to a grievance claim or a malpractice action (even if without merit)!

Notice that I have not presented the option of "suing the client." I do not think this makes any sense, unless the fees are so large that you believe it is worth pursuing, despite the potential negatives, or for the "principle of it." As to the latter, what do you tell your clients when they want to sue on principle? My patented response is: It is not worth it—you will not likely be happy when the dust settles.

Remember, while the ball is in your court, no one is paying for the time you spend on collecting the fee. One tip here is to provide in your engagement agreement for an interest charge on any unpaid balance. At the very least, this will allow for leverage and a greater awareness on the client's part that he or she not only owes you money, but interest will accrue. In our office, we have an interest charge of 12 percent per annum, assessed on any accounts receivable outstanding for more than 30 days. Often, we let the client know that if they pay the outstanding fee, then we will waive the interest charge.

Ask yourself this question: How did I get here? What is it all about? In our office, we ask for our entire fixed fee for our long term care/estate plan, up front. The possibility of an accounts receivable is zero. If the client resists, then we make a decision, whether to request a portion up front and the balance upon completion. A judgment call in our office: Is the attorney comfortable with the client's intention to meet this financial obligation?

ACT FOUR: A FADING MEMORY. You did great work. The job is done. The client is happy. Beware. "Happy" can be fleeting. For each day that you have an outstanding accounts receivable, the chance of collecting the money is diminished. Consultants tell us that your chances of collecting your fees after 90 days are greatly diminished and almost nil after 180 days. Make sure you are diligent in following up in the collection of this money. You deserve it.

It is important that you have a software program that provides an accounts receivable report. At least once a month, you should review your accounts receivable report and then implement an action plan to collect the money. Make sure that your report "ages" your receivable. What do I mean? The report should list the clients who owe you money according to time: 1-30 days, 31-60 days, 61-90 days, 91-180 days, more than 180 days. Set your priorities. As the receivable ages, you must really stay on top of its collection or you may have to write it off.

ACT FIVE: THE REWARD. The reward is enormous. You can have more money in the bank. You can spend your time serving clients, rather than chasing them for money. You might even decide to take a day off.

Realistically, you are going to have receivables. It all depends on the type of service you are providing and your approach to payment. If you are waiting on fees, which are subject to a court order, you will have to wait, but be prepared with a procedure when the day comes to collect. In estate planning and long term care planning, you should not have accounts receivable.

Having a procedure in place as to how you charge and collect fees can literally improve the quality of your professional life. Do not let the cash flow stress get to you. Charge reasonable fees, provide quality work and be compensated accordingly.

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Advance Directive News

New Legislation Expands the Reach of Surrogate Health Care Decision Making

By Ellen G. Makofsky

The New York legislature recently enacted the Health Care Decisions Act for Persons with Mental Retardation ("the Act").[1] The Act provides that under certain circumstances, where a mentally retarded person lacks sufficient capacity to make health care decisions, a 17-A guardian may make health care decisions for that person, including the right to withhold or withdraw life-sustaining treatment. Although Article 17-A addresses the procedure for appointing guardians for both the mentally retarded[2] and developmentally disabled,[3] the Act applies only to mentally retarded individuals and does not apply to the developmentally disabled.[4] The Act is a beginning salvo for providing health care decision making for those unable to direct their own care.

Surrogate decision making for persons who have never had capacity has long been a problem in New York State. New York law requires that a person's wishes in regard to advance directives be established by "clear and convincing evidence" of what the incapacitated person would have wanted in regard to life-sustaining measures.[5] A health care proxy executed by an individual possessing capacity can be used to appoint a health care agent with authority to make all health care decisions including end of life decision making for that individual.[6] A living will and oral statements made by an individual may meet the test of clear and convincing evidence. Where, however, an individual never had sufficient capacity to execute a health care proxy or to evidence the intent necessary in regard to life-sustaining measures, surrogate decision making was not an available option.

The Act, which becomes effective on March 16, 2003, provides an option for surrogate health care decision making for the mentally retarded person. The Act requires that when an individual is certified as mentally retarded as part of the guardianship proceeding, the certification shall include whether the mentally retarded person has the capacity to make health care decisions.[7] Once a certification is made that capacity is lacking, the Act provides that the appointed guardian shall have the authority "to make any and all health care decisions, . . . on behalf of the mentally retarded person that such person could make if such person had capacity. Such decisions may include decisions to withhold or withdraw life-sustaining treatment."[8] The power granted to the Article 17-A guardian is more expansive than the power given to a guardian appointed under Article 81 of the Mental Hygiene Law, which permits a guardian only to consent to or refuse generally accepted routine or major medical or dental treatment.[9] Furthermore, the court is not readily inclined to expand the power of an Article 81 guardian to make health care decisions.[10]

The Act sets guidelines in regard to the health care decision-making standard for the mentally retarded person certified as lacking capacity to make health care decisions. It requires the guardian to base all advocacy and health care decision making solely and exclusively on the best interests of the mentally retarded person, and when reasonably known or ascertainable . . ., on the mentally retarded person's wishes, including moral and religious beliefs."[11] The Act provides the guardian with a list of considerations to determine whether the best interest standard has been met.[12]

The Act provides that the guardian "shall have the affirmative obligation to advocate for the full and efficacious provision of health care, including life-sustaining treatment."[13] That said, where the guardian makes a decision to withdraw or withhold life-sustaining treatment, the mentally retarded person must be re-certified and a two-step evaluation must be undertaken. The attending physician, along with a consulting physician, must note on the patient's chart that the mentally retarded person has a medical condition that is terminal, or that the patient is permanently unconscious, or the medical condition which requires life-sustaining treatment is irreversible and will continue indefinitely. In the second step, the physicians must determine the life-sustaining treatment would impose an extraordinary burden on the mentally retarded person in light of the person's medical condition and the expected outcome. Where the decision is to withdraw or withhold artificially provided nutrition or hydration, the physicians additionally must specifically note that there is no reasonable hope of maintaining life, or that the artificially provided nutrition or hydration poses an extraordinary burden.[14]

The Act, in addition to providing the procedures for withholding life-sustaining treatment, includes certain notification requirements and a procedure for

dealing with objections to the health care decisions made by the guardian. Where there are disputes, the Act provides for a special proceeding to review objections to the withdrawal or withholding of life-sustaining treatment.[15]

The Act is not a panacea. It is cumbersome and limited. The Act does not empower Article 81 guardians or 17-A guardians for the developmentally disabled. It is filled with the language of compromise and has yet to meet the test of practical implementation or court interpretation. Yet, with all these limitations, the Act is still an important step down the road to allowing the impaired equal access to surrogate health care decision making in New York State.

Endnotes

1. Chapter 500 of the laws of 2002.
2. SCPA 1750 defines a mentally retarded person as

   > a person who has been certified by one licensed physician and one licensed psychologist, or by two licensed physicians at least one of whom is familiar with or has professional knowledge in the care and treatment of persons with mental retardation, having qualifications to make such certification as being incapable to manage him or herself and/or his or her affairs by reason of mental retardation and that such condition is permanent in nature or likely to continue indefinitely.

3. SCPA 1750-a defines a developmentally disabled person as

   > a person who has been certified by one licensed physician and one licensed psychologist, or by two licensed physicians at least one of whom is familiar with or has professional knowledge in the care and treatment of persons with developmental disabilities, having qualifications to make such certification, as having an impaired ability to understand and appreciate the nature and consequences of the decisions which result in such person being incapable of managing himself or herself and/or his or her affairs by reason of developmental disability and that such condition is permanent in nature or likely to continue indefinitely and whose disability: 1. is attributable to cerebral palsy, epilepsy, neurological impairment, autism or traumatic head injury; 2. is attributable to any other condition or a person found to be closely related to mental retardation because such condition results in similar impairment of general intellectual functioning or adaptive behavior to that of mentally retarded person; or 3. is attributable to dyslexia resulting from a disability described in subdivision one or two of this section or from mental retardation; and 4. originated before such person attains age twenty-two, provided, however, that no such age of origination shall apply for the purposes of this article to a person with traumatic head injury.

4. The Act amended section 1750 of the Surrogate's Court Procedure Act to add section 1750-b and does not amend section 1750-a.
5. *In re O'Connor*, 72 N.Y.2d 517, 534 N.Y.S.2d 886 (1988).
6. N.Y. Pub. Health Law art. 29-C.
7. S.4622-B Session 2001-2002. SCPA § 1750(1) as amended.
8. SCPA 1750-b(1) as amended.
9. Mental Hygiene Law § 81.22
10. Where an application was made to the court under Article 81 to expand the powers of a guardian to direct whether life-sustaining treatment should be provided to or withheld from an incapacitated person, the court denied the application where the guardian was unable to present clear and convincing evidence of the incapacitated person's prior expressed wishes regarding life-sustaining equipment. *In re Barsky*, 627 N.Y.S.2d 903 (1995).
11. SCPA 1750-b(2)(a) as amended.
12. In assessing the mentally retarded person's best interests the Act directs that the guardian shall include consideration of

    > the dignity and uniqueness of every person; the preservation, improvement or restoration of the mentally retarded person's health; the relief of the mentally retarded person's suffering by means of palliative care and pain management; the unique nature of artificially provided nutrition or hydration, and the effect it may have on the mentally retarded person; and the entire medical condition of the person.

    Id., § 1750-b(2)(b).
13. *Id.*, § 1750-b(4).
14. *Id.*, § 1750-b(4)(b).
15. *Id.*, § 1750-b(4)(c).

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Ms. Makofsky is a member of the New York State Bar Association (NYSBA) and serves on its Elder Law Section's Executive Committee. She is Chair of the Long Term Care Reform Committee of the Elder Law Section. She is also a member of the NYSBA's Trusts and Estates Law Section. Ms. Makofsky is a member of Nassau County Bar Association, Elder Law, Social Services and Health Advisory Committee and the Surrogate's Court Trusts and Estates Committee. She is a member of the National Academy of Elder Law Attorneys, Inc. (NAELA). Ms. Makofsky is also a member of the Estate Planning Council of Nassau County, Inc.

Ms. Makofsky currently serves as co-chair of the Long Island Alzheimer's Foundation (LIAF) Legal Advisory Board and is the immediate past president of the Gerontology Professionals of Long Island, Nassau Chapter. She is the former co-chair of the Senior Umbrella Network of Nassau. She serves on the Board of Directors of Landmark on Main Street.

Capacity News

What Do You Do When Your Client Is Illiterate or Speaks a Foreign Language?

By Michael L. Pfeifer

What do you do when your client cannot read his or her will? What do you do when the client cannot even speak the English language? What follows are some cases that give us guidance on these questions.

* * *

In re Regan,[1] the testator could not read or write. She signed the will by a mark, "followed by the usual attestation clause."[2] After trial, the Surrogate directed verdict for the proponent of the will and admitted the will to probate. An appeal ensued with the appellant claiming that "proponent failed to establish due execution of the will because the decedent being illiterate, not able to read or write, there was no evidence that she knew the contents of the instrument signed by her."[3] There was no evidence presented in the record that would indicate that the testator knew the contents of her will. The Surrogate was reversed and the case remanded for a new trial.

The court conceded that in an ordinary case, the proponent would not have to prove that the testator knew the contents of the will and that it expressed his or her intentions. However:

> ". . .[W]ith regard to both blind and illiterate, and all who cannot read what is written out as their will, requires satisfactory proof of some kind to the effect that the testator knew and approved of the contents of the will which was executed as his own. Such a will may be read over to the testator before signing, apart from his witnesses; or it may be shown that the contents were correctly made known to him without any formal reading at all; provided it appear, on the whole, that the instrument as drawn up and executed constituted his own testamentary disposition as intended by him. Less than this, however, is unacceptable." (Schouler Wills [5th ed.], § 317.) "In the case of persons who are so ill, or otherwise disabled as to be unable to write, as well as in cases of illiteracy, there is no presumption that the testator knew what he was doing; but the knowledge of the contents of the will and the character of the paper have to be proved." (Jessup Surr. [4th ed.] 331.)[4]

In re Gerdik,[5] the testator spoke a foreign language of Slavic origin. She signed her will with an "X." The court stated, "Under circumstances where the decedent is illiterate, the proponent must show more than the usual factum of subscription and execution by the decedent (*Matter of Regan,* 206 App. Div. 403)." The attorney draftsman and all of the subscribing witnesses testified that the will was read to the testator. At the time of execution, the testator stated in English that she wanted "everything left to John Fescura."[6] The court held that this was enough to show due execution.

In re Simone,[7] the testator was unable to read and write both Italian and English. Although she had an understandable knowledge of spoken English, she spoke Italian by choice.

When the testator was advised that one of her sons had a terminal illness, she called her nephew, a suspended attorney, to come and see her immediately. The testator wanted to remove her son from her will because "[s]he understood correctly that, if he predeceased her, his daughter, the contestant herein, would succeed to his interest. She did not want this to occur."[8]

The court's analysis is interesting and instructive:

> This leaves one question and the only real basis upon which the contestant can object to this will. Did this elderly lady, who was illiterate in both Italian and English, understand the nature of the document which she signed? More particularly, was the nature of the document adequately explained to her? The court must be satisfied in order to admit the will to probate that the testatrix understood the nature of the document. This presents little difficulty when the person is familiar with the language in which the document is written. When one is under a disability as to the language, other proof

> must be submitted that the instrument was fully understood.
>
> Mr. Battaglini testified that he explained the dispositions of the will in Italian and English to Maria Simone. He did not translate it word for word because his Italian was not that precise. Of the subscribing witnesses, only Anita George was fully conversant in Italian and she was hard of hearing.
>
> If the instrument before the court were extremely complicated and differed from the prior will in many respects, a more serious problem would exist. However, there is really only one significant change between the will drawn in 1952 and the present instrument before the court. In the present instrument, Robert is specifically excluded. . .
>
> The court has examined the two instruments carefully and finds them substantially identical with two exceptions. In the present instrument (1) Robert is excluded, and (2) Mr. Battaglini is named as executor instead of Joseph Simone, another son of the decedent. . .
>
> Maria Simone had also told her niece, Anita George, about excluding Robert from her will. The instrument offered for probate does specifically exclude Robert. From the testimony given, the court determines that Maria Simone was adequately advised of the contents of the proposed will. Relying on the information given to her, she was satisfied that the instrument submitted for her signature expressed her wishes. Word-for word translation is not a necessary requisite. If the instrument submitted to the court effects the expressed wish of Maria Simone, it should stand as her will.[9]

I think it is interesting that the will was admitted to probate despite the fact the attorney explaining the document was limited in his ability to translate Italian. What seems to have saved the day for the proponent was the lack of complexity of proffered will and its similarity to the testator's prior will. There was also extrinsic evidence showing that the will comported with the testator's intent. One can infer that more would be needed if the will before the court had been more complex and a marked departure from the earlier will.

In re Watson,[10] the testator spoke fluently only in Slovak. The testator's son, and the proponent of the will, told the drafting attorney what provisions his father allegedly wanted in his will. "However, the attorney took the time to assure that the testator understood his explanation in English of the proposed terms of the will and assented thereto, and it is conceded that while the testator did not read English, he did speak and could understand English when spoken slowly as the attorney testified he did."[11] The court noted that where the testator does not speak English the proponent has a greater burden in establishing that the intent of the testator is being carried out. However, in this instance, the court held that the proponent met his burden.

In re Fico,[12] "[t]he uncontroverted evidence adduced at trial establishes that the draftsman of the will, who had been the testatrix's attorney for over 40 years, fully explained the provisions of the will to her in Italian, which was her native language *(see, Matter of Albarino,* 45 Misc.2d 216, *affd* 23 A.D.2d 535, *affd* 16 N.Y.2d 927; *Matter of Holly,* 13 N.Y.2d 746; *Matter of Simone,* 53 Misc.2d 314). The record additionally establishes that the testatrix was aware of the extent of her property, and of the consequences of her disposition. Under these circumstances, the jury could not have rationally concluded that the testatrix was unaware of contents and nature of her will, and thus the court properly awarded judgment as a matter of law in favor of the proponent *(see, Matter of Kumstar,* 66 N.Y.2d 691, 693; *Matter of Elco,* 153 A.D.2d 860; *Matter of Minasian,* 149 A.D.2d 511)."[13]

* * *

It seems clear that the proponent of a will has a higher burden where the testator is illiterate in English. At the very least, the will should be fully explained to the testator in a language in which the testator is fluent. The attorney should avoid using a proposed beneficiary of the will to translate since his or her translation will be suspect. If the attorney wishes to be conservative, the entire document will be read to the testator at the time of execution. Make sure the witnesses are aware that the terms of the will were explained to the testator in his or her language. The self-proving affidavit should accurately reflect the circumstances of execution. At the time of execution, there should be no issue that the testator fully understands the will and that it expresses his or her intentions. The attorney should probably draft a memorandum to the file detailing what was done to ensure that this is so.

Endnotes

1. 206 A.D. 403, 201 N.Y.S. 431 (2d Dep't 1923).
2. *Id.*, 404.
3. *Id.*, 405.
4. *Id.*, 406-407.
5. 30 Misc.. 2d 1086, 220 N.Y.S.2d 706 (Sur. Ct., Nassau Co. 1961).
6. *Id.*, 1087.
7. 53 Misc.. 2d 314, 278 N.Y.S.2d 928 (Sur. Ct., Broome Co. 1967).
8. *Id.*, 316.
9. *Id.*, 317-318.
10. 37 A.D.2d 897, __ N.Y.S.2d __ (3d Dep't 1971).
11. *Id.*, 897.
12. 169 A.D.2d 832, 565 N.Y.S.2d 202 (2d Dep't 1991).
13. *Id.*, 832-833.

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Lawyer Assistance Program Can Help Attorneys with Alcoholism and Substance Abuse Problems

Alcoholism and substance abuse are problems that can afflict any member of the bar at any time. Indeed, the percentage of lawyers and judges suffering from alcoholism and drug addiction is significantly greater than the general population. Because of the pervasiveness of the problem in the profession and the devastation suffered not only by the alcoholic or addict but also by their family members, partners and clients, the Bar Association formed the Committee on Lawyer Alcoholism and Drug Addiction in 1978. To help the Committee address the problem, the Lawyer Assistance Program, headed by Ray Lopez, was created in 1990. Under Ray's direction, the State Bar program is on the cutting edge of alcoholism and drug addiction education, intervention, treatment and is nationally respected as one of the leading programs in the field. Despite the great success of the program, over 5,000 referrals in twelve years, there are thousands of lawyers and judges who do not know about the program and what it can do for them. Recently, Patricia K. Bucklin, Executive Director of the New York State Bar Association, asked all Section and Committee Chairs to tell their members about the Committee and what it can do for any of their members who are struggling with alcohol or substance abuse problems.

Currently there are 68 Committee members and a vast network of volunteers. Most are attorneys and judges of Supreme Court, County Court, Family Court, and Civil Court. The Committee is aided by professional counselors, like Ray Lopez in Albany, and Eileen Travis in New York City, and many others serving local bar associations.

The primary functions of the Committee, with Ray Lopez's guidance and direction, are twofold: 1) to assist attorneys, judges, and law school students and their families who are suffering from alcoholism, drug abuse, depression and stress-related issues through abuse interventions and planning, sobriety monitoring for appellate courts and disciplinary committees, and participation in treatment programs and twelve step groups with attorneys on a local level; and 2) to educate the profession as a whole to detect the warning signs by participation in presentations at law schools, judiciary conferences, disciplinary committees and bar association committees on a statewide and local basis.

One year ago, Chief Justice Judith S. Kaye formed the Lawyer Assistance Trust to study the problems of alcoholism and substance abuse in the legal profession and to provide assistance to groups addressing these problems. Eight of the Committee's 68 members serve as Trustees.

Information on outreach concerning attorneys' personal problems with alcohol and drug abuse and possible grants for efforts related to attorney wellness, in the areas of substance abuse, stress management and depression is available to all NYSBA Sections and Committees. Committee members would welcome the opportunity to speak at Committee or Section events regarding stress management issues, substance abuse, alcoholism and depression among attorneys.

All services provided by the LAP or Committee members are confidential and protected by Section 499 of the Judiciary Law.

For more information about the Committee, to arrange for a presentation by Committee members or for a confidential referral of an attorney who you believe has a problem with alcohol, substance abuse, stress management or depression, contact the Lawyer Assistance Program at 1-800-255-0569.

Snowbird News

Medicaid Planning with Mortgages

Florida Sunshine for the New York Elder Law Attorney*

By Scott M. Solkoff

A family comes to me with the following facts:

Margie and Harold are living at the Palm Beach Senior Place, a senior community offering independent, assisted living and skilled nursing options. Margie is in the assisted living wing and Harold is in the skilled nursing wing. The money is going fast. When they moved from Great Neck to Delray Beach last November they came with $450,000. Now, after nine months of hemorrhaging money, Margie and Harold are down to $330,000 plus the old family home in Great Neck. The home is valued at $240,000. Margie and Harold make it clear that the home should stay in the family if at all possible.

Especially in southeast Florida, clients regularly come to Florida elder law attorneys with New York real estate among their assets. If the home cannot be justified as exempt from being counted as a resource, it must be sold or sheltered before Medicaid eligibility can be had. Typically, if a person is applying for Medicaid in Florida, the New York real estate is a countable resource.

What Margie and Harold really want is for the home to be transferred to their children and for their cash assets to be protected. If the home is transferred to the children with nothing received in exchange, Margie and Harold have made a gift. In Florida, with a penalty divisor of $3,300, that gift would amount to a 72-month period of ineligibility (albeit with only a 36-month look-back period). Therefore, the home cannot just be "gifted" away. If the home is transferred to the children, something must be received in exchange for the home that is at least equal in amount to the fair market value of the home.

One way in which we shelter the real estate of our Florida clients is through the use of a secured loan transaction. Margie and Harold would transfer the Great Neck home to their three children; Larry, Moe and Curly. In exchange for the home, Larry, Moe and Curly execute a promissory note promising to pay $240,000 (100 percent of the fair market value) to Margie and Harold. The note would be for a 30-year term at a reasonable (market) interest rate just as a bank would do if the bank were the lender. In other words, Margie and Harold have sold the home to the kids with 100 percent financing. Like a bank, however, the lenders require security for this loan and Margie and Harold therefore take a mortgage on the property. Properly drafted, the mortgage itself cannot be counted as an available resource. What we have done therefore, is taken a $240,000 family home and converted it to a non-countable mortgage.

While we prepare the necessary mortgage language, the New York attorney "New York-izes" the document and records it. This is the real thing. Real interest rate. Real recording. Real mortgage payments.

> *"Typically, if a person is applying for Medicaid in Florida, the New York real estate is a countable resource."*

Real mortgage payments? Yes. Larry, Moe and Curly have to make their mortgage payments. If Harold is applying for Medicaid and Margie is not applying, then we do the entire transaction through Margie so that all mortgage payments go to Margie. If Margie is not applying for Medicaid, she may earn unlimited income and so all of the mortgage payments can be used by Margie for whatever purpose she requires. If Margie is also applying for Medicaid or if she later applies for Medicaid, the mortgage payments must go toward the cost of her care during her receipt of benefits (i.e., the mortgage payments would be included as part of her "patient responsibility"). We have also employed this technique for single Medicaid applicants where the plan from the beginning is that mortgage payments would go toward cost of care. Another little side benefit is that if the kids stop making mortgage payments, Margie can foreclose.

The money for the mortgage payments usually comes from one of three sources: payments from the children, rental income or transferred resources. Payments may be made directly from the children since they are ultimately the owners of the property. Payment may also be generated by getting a tenant in the home. Most commonly, payments are generated

through resources that had been transferred from Mom and Dad to the kids. This latter technique might mean, for example, that Harold and Margie have transferred some or all of their cash assets to the children in the form of incremental gifts. It might mean that Harold and Margie transferred $X to their children in exchange for non-countable life estate interests in Larry, Moe and Curly's homes (more on that in another installment of *Florida Sunshine*!). It might mean a transfer of cash in exchange for personal care services. Etc. Etc. The money to pay the mortgage payments, though legally belonging to the children, could therefore have originated with Mom and Dad.

Because the notes are amortized out for 30 years, the payments are relatively small. For example, $240,000 at six percent would bring a monthly payment of $1,438.92. So long as the community spouse does not require Medicaid, none of the money is lost. If the community spouse needs Medicaid, then the monthly payments go toward the cost of care so long as that care is needed. There may be a tax advantage in the payments. The Internal Revenue Code allows interest on mortgage payments to be tax deductible under certain instances. Note also that there may be a capital gains event on the "sale" of the home.

All is well for Harold and Margie with this transaction. Harold qualifies for ICP Medicaid and Margie stays in assisted living on private-pay (were she in a participating Medicaid-Waiver facility she, too, might apply for Medicaid). They did so by legally protecting their cash assets while preserving the family home.

Federal law requires the states to attempt recovery of Medicaid dollars from the estates of Medicaid recipients. If Margie owns the mortgage and herself never receives Medicaid, the state has no recovery right. If Margie owns the mortgage and does receive Medicaid, the mortgage is an asset of her estate and therefore subject to estate recovery upon her death. Additional steps, beyond the scope of this article, may be taken to safeguard the mortgage from estate recovery.

"Federal law requires the states to attempt recovery of Medicaid dollars from the estates of Medicaid recipients."

Mortgage plans may shelter cash assets as well as real estate. When sheltering cash assets, the money is loaned to a child and secured with a note and mortgage on that child's home. Whether a child's home or the parents' home is being used for security, sometimes the real estate is sold prior to the mortgage holder's death. For example, if Larry, Moe and Curly were to sell the Great Neck home, Margie would be the mortgage holder. They would have to pay Margie off at closing. If Margie herself is not on Medicaid, then this infusion of cash does not affect Harold's eligibility. If Margie is on Medicaid, the proceeds from the mortgage pay-off would be re-sheltered the same calendar month the proceeds are received, thereby incurring no loss of benefits.

For Harold and Margie, this Florida sunshine means saving their New York home. In the next installment of *Florida Sunshine*, we will delve deeper into real estate as a Medicaid planning tool for the New York Floridian.

***Second in a series of articles by Scott M. Solkoff relating to the New York Floridian. Scott M. Solkoff is a Florida bar board-certified attorney, concentrating in elder law and primarily serving clients in southeast Florida. If you have requests for future installments or should you have any questions or comments, the author may be reached at (954) 765-1035 or (561) 733-4242.**

GUARDIANSHIP NEWS

Rules on Fiduciary Appointments

By Robert Kruger

On September 26, 2002, the Administrative Board, composed of the Chief Judge and the Presiding Justices of the Appellate Division of the four Judicial Departments, agreed on rules governing fiduciary appointments, a matter of considerable importance to those whose practice includes guardianship.

The rules (or perhaps they might be characterized as recommendations) must be adopted by the Court of Appeals to become effective, most probably, sometime in 2003.

The information conveyed here is the product of an oral report given by Charles Devlin, Director of Guardianship Services, at the October 11, 2002, Elderlaw Advanced Institute at West Point.

Nothing was distributed in writing and the description of the new "rules," with all caveats attached, reflected items reported by Mr. Devlin, with such exegesis as questions allowed, and subject to the vagaries of an imperfect memory.

Since the rules are unlikely to be issued before the next issue of the *Elder Law Attorney* is published, it is likely that this report will remain current by publication date.

- A fault line is drawn between fiduciary list appointments on the one hand and family/party nominee/designees on the other. Unless specifically noted, the rules set forth below apply to fiduciary list appointments only, not to the designee/nominee appointments.

- The prohibition against accepting more than one appointment yielding $5,000 or more within a 12-month period has been changed slightly to a prohibition against accepting more than one such appointment in a calendar year.

  Comment: In 2003, you accept the first appointment in April. That bans you from accepting a second such appointment in 2003. In 2004, a "good" appointment in January is permitted. If the "good" appointment were made in December 2003, it could not be accepted, because the date of appointment, not receipt of funds, will govern the $5,000 rule.

  Comment: You will file your OCA forms upon receiving your appointment. Let us suppose that, after you have received your first $5,000-plus appointment, you receive a modest appointment. You accept this appointment and file your OCAs, suspecting nothing. This "smaller" case, however, takes an unexpected turn, such as a family fight or whatever, and you are awarded more than $5,000. Will OCA file charges against you for violating the rules? We must develop language to add to the OCA form to protect ourselves because we are filing our acceptance before we know much about the case.

- There is a $50,000 income cap on fiduciary list appointments per calendar year.

  Comment: Assuming you exceed your cap in 2003, you are "benched" for 2004 . . . you may receive no fiduciary list appointments in 2004. And, if you exceed the cap (from post-2002 appointments only) in 2004, you remain benched.

  Comment: Beware the small guardianship assignment, which becomes a large one because you discover previously undisclosed funds.

  Comment: You must remain aware of fiduciary list income constantly; an unexpectedly large fee or commission can put you over $50,000 and cause you to forfeit appointments in the following years.

Comment: The $50,000 rule is probably counted from the date of the court order awarding fees or commissions; it will not be based upon actual receipt.

Comment: Many fees awarded are not received; there is probably, at present, no "forgiveness" in this rule.

- Appointments preceding the effective date of the rules are grandfathered. They don't count. Only appointments made after the rules become effective count.
- Legal services performed for lay guardians and family designee guardians are not secondary appointments.

Comment: Therefore, doing an annual accounting or a real estate sale for a client who is a lay guardian will not count against the cap.

- There are no exceptions for special expertise. Once capped, you remain capped.

Comment: This manifests profound distrust of the judges evading or abusing the "expertise" exception.

- Court examiners are capped at $50,000 as well.

Comment: As a court examiner in the First Department, probably an ex-court examiner by the time this goes to press, the amount of work is quite substantial for a relatively modest return. Court examiners will, I predict, be hard to find or, if found, harder to retain.

- For the fiduciary list guardian appointee, you cannot do your own legal work without making a strong case to the court.

Comment: What about annual accountings: Must an application be brought by a guardian to do his or her own accounting? I do not know.

Comment: As this is written, the rules have not been approved by the Court of Appeals. They are not yet published and are not expected to be until year's end, if not later. Therefore, I don't have the language of the rule, only the concept. Still, the sense of the rule is clearly hostile to routine exceptions and granting permission to a fiduciary list guardian to act as his/her own attorney cannot be assumed.

- For the fiduciary list guardian, permission to hire a broker, an accountant, an appraiser, a building manager, etc. is required. I do not know if social workers are included or if permission must be obtained to hire such professionals by the nominee/designee guardian.
- There is an absolute prohibition against appointing a court-appointed attorney as guardian.
- There is a strong recommendation, but not an absolute prohibition, against appointing a court evaluator as guardian.
- There is a long list of categories of persons who are prohibited from appointments, including judges within two (2) years of leaving the bench.
- Not-for-profit programs such as community guardians, are excluded from income cap and secondary appointment rules.

Conclusion

The impact of these rules cannot be measured until they are, with finality, adopted. Until that time, judges are, often, anticipating the new rules and, just as often, mistaking their impact.

We who practice guardianship must collect anecdotes, good and bad, reflecting the way in which courts deal with guardianship cases.

I would urge the Bar to report their anecdotes to the author, who will be keeping a file for use in attempting to monitor the administration of justice in this area, with particular emphasis on the impact on the AIP.

For example, one update attorney, attending the West Point seminar, has failed to be given a hearing for six months. The case caption, venue, index number and judge presiding, together with a short narrative of the salient events, should be reported. This is but one example of maladministration. The bureaucratic bunker mentality of other judges manifests itself in other ways.

Without exhausting the possibilities, the author has knowledge of court evaluators who do not investigate or, in two instances, bother to attend the hearing. One judge downstate doesn't hold a hearing before appointing a guardian. Another downstate judge refuses to sign an order to show cause in infant cases.

In addition, complaints about the fees being awarded abound; low attorney's fees, however, do not hurt AIPs. I solicit these anecdotes as well but, in this climate, it is best not to be precipitous on the fees issue.

With full awareness that the Bar may not be able to use this information solicited until 2004, the time to start collecting this information is *now and at once*.

I believe strongly that we will be given a hearing on the effect of these rules, even though I feel just as strongly that we were not heard in the process that led to the adoption of the rules.

Please fax or mail such information to the author as follows: Robert Kruger, fax (212) 608-3785, e-mail: RobertKruger@aol.com.

Robert Kruger is the Chairman of the Committee on Guardians and Fiduciaries, Elder Law Section of the New York State Bar Association. He is also Chairman of the Subcommittee of Financial Abuse of the Elderly, Trusts and Estates Section, New York State Bar Association. Mr. Kruger is an author of the chapter on guardianship judgments in *Guardianship Practice in New York State* (NYSBA 1997) and Vice President (four years) and a member of the Board of Directors (ten years) for the New York City Alzheimer's Association. He was the Coordinator of Article 81 (Guardianship) training course from 1993 through 1997 at the Kings County Bar Association and has experience as a guardian, court evaluator and court-appointed attorney in guardianship proceedings. Robert Kruger is a member of the New York State Bar (1964) and the New Jersey Bar (1966). He graduated from the University of Pennsylvania Law School in 1963 and the University of Pennsylvania (Wharton School of Finance (B.S. 1960)).

Public Elder Law Attorney News

Family Health Plus—New Health Care Coverage Option for New Yorkers Under Age 65

By Valerie J. Bogart

Family Health Plus (FHP) is a new health insurance program for uninsured adult New Yorkers between the ages of 19-64.[1] The state legislature enacted this program as part of the Health Care Reform Act of 2000 (HCRA 2000).[2] The program required approval by the federal government through a "Section 1115 waiver" because the program utilizes federal Medicaid funds to provide a lesser benefits package than is otherwise provided through Medicaid, and is limited to managed care rather than fee-for-service coverage.[3] As of September 2002, FHP enrollment was at 83,114 statewide, of which 37,000 enrollees were in New York City.[4]

The program's income limits for singles and childless couples between the ages of 19-64 are set at 100 percent of the Federal Poverty Level, which is higher than the regular Medicaid levels. For single adults or couples, age 19-64, living as caretaker relatives with at least one child under 21, the income limit increased from 133 to 150 percent of the Federal Poverty Level, effective October 2002.

The 2002 income levels are as follows, including increased figures for adults living with minor age children as of October 1, 2002.[5]

Household Size	**1**	**2**
MEDICAID:		
age 65 or over, or disabled	$634	$925
FHP:		
Singles, childless couples (age 19-64)	$739	$995
Individual (age 19-64) living with one child under 21 (If child in home, add $385 per month for each additional household member—a second parent or additional children)	N/A	$1493

I. Who Is FHP For?

Family Health Plus may be the *only* health care coverage available to people between the ages of 19-64 who do not qualify for Medicaid at all. It also may be a preferred alternative to some who qualify for Medicaid, but only with an income or resource spend-down.

1. *People who will most benefit from this program are those between the ages of 19-64 who do not qualify for Medicaid at all*. For people under age 65, eligibility for Medicaid is much more limited than for persons who are age 65 or over. For persons under age 65, there are two limited paths to receiving Medicaid. One way is to be in a favored federal category, which includes (a) people who are disabled within the strict definition used by the Social Security Administration, or (b) caretakers of children under age 21 who live with them, whether parent, grandparent, or other relationship. Medicaid views people in these two categories the same as people over age 65—they are fully eligible for Medicaid with incomes of $634 for singles and $925 for couples, and with resources under limits of $3,800 for singles and $5,550 for couples, with some exemptions. If their incomes or resources exceed these limits, they may still qualify if they "spend down" their excess income or resources on medical expenses.

Many older people do not qualify for Medicaid in this way—they are not disabled, nor are they caring for minor-age children (or grandchildren) in their homes. The only way these individuals can qualify for Medicaid is to be very poor—with incomes so low that they would qualify for public assistance (welfare)—$352.10 per month for singles and $468.50 for couples in New York City. (Because of varying shelter allowances, the income limits vary slightly across the state.) Such households must also have savings under $2,000, or $3,000 if age 60 or over. These limits are so low that most people—whether early retirees receiving Social Security or pensions, part-time workers, or those receiving unemployment insurance—do not qualify. Nor are these individuals allowed to spend down their excess income on medical expenses to qualify for Medicaid. They are not permitted to spend down to any income limit. If their income and resources are above the below-poverty "welfare" level—only $352.10 per month for singles—they are simply not eligible for Medicaid.

It is the latter group—those under age 65 who are not disabled and who are not caring for children—for whom FHP presents a new opportunity to obtain health insurance. A typical retired or unemployed person in her late 50s or early 60s has no minor chil-

dren living at home, is not disabled under Social Security's long-term definition, but has income over $352 per month. Before, even if her income was below the regular Medicaid limit of $634, she was not eligible for Medicaid because that higher income limit applies only to the disabled, elderly, or caretakers of children. Now she can have income up to $739 per month, or $995 for couples, and be insured under FHP.

Significantly, one may not spend down to qualify for FHP. One's gross income must be below the limits.

2. *With no resource limit, FHP is an alternative for persons age 19-64 whose income may be within the Medicaid limits, but who have excess resources and do not want to spend them down*. FHP has no limit on an individual's assets. Of course, if one's savings generate income or dividends, that income is counted and may render one ineligible for the program. However, the absence of any asset limitation makes FHP a viable alternative for people in their 50s and early 60s who may have acquired substantial pensions, IRAs, and annuities.

3. *Lower income people eligible for regular Medicaid with a spend-down may opt instead for FHP with no spend-down*. A disabled person or one caring for a child or grandchild may choose FHP even though he or she would qualify for Medicaid with a spend-down.[6] Singles can benefit from the higher income limit—$739 per month in FHP compared to $654 in Medicaid (after the $20 monthly income disregard). Parents/caretaker relatives living with children benefit by much higher income limits at 150 percent of the Federal Poverty Level (see above).

Individuals who have a choice between Medicaid with a spend-down and FHP must evaluate their own individual circumstances. One factor is whether the more-limited FHP service package meets their medical needs (see more below). Another factor is whether an individual may be able to meet the Medicaid spend-down by obtaining "credit" for past incurred medical bills or recently paid bills.[7] If the spend-down is met by these past bills, then Medicaid may be preferable because of its broader benefit package available through fee-for-service providers, not solely through managed care.

II. Other Eligibility Criteria for FHP[8]

1. **Residency**. All FHP enrollees must be New York State residents.

2. **Immigration**. Like regular Medicaid, all qualified aliens (including lawful permanent residents, or green card holders, regardless of when they entered the United States, *and* people who are permanently residing under color of law (PRUCOL)) are eligible for FHP.[9] However, unlike the Child Health Plus program, undocumented persons and non-immigrants are *not* eligible for FHP.

3. **Age**. All FHP enrollees must be between the ages of 19 and 64.

4. **Income**. One *may not* spend down to the FHP income level.

5. **Resources**. There are no resource/assets test for FHP.

6. **Third-Party Health Insurance.** Unlike Medicaid, applicants with other health insurance, including Medicare Part A or Part B, are generally not eligible for FHP, except in enumerated situations where coverage is not equivalent to a minimum coverage standard. Examples of coverage which would not bar FHP eligibility are accident-only coverage, auto liability insurance, dental-only, vision-only, long term care-only, or other specified disease coverage.[10]

   When the FHP program began, the State Department of Health barred any applicant from FHP enrollment if he or she was paying for COBRA or other private insurance coverage at the time of application, even if the applicant intended to drop this costly insurance once enrolled in FHP. Advocacy groups such as New Yorkers for Accessible Health Coverage (NYFAHC) pointed out the risk of individuals dropping their costly COBRA or other private coverage in hopes of getting free FHP insurance, then being denied FHP and having no coverage at all.[11] In August 2002, the state amended its policy to allow an individual paying for private, non-employer-based insurance, including COBRA, to enroll in FHP if the individual states in writing that he or she plans to terminate the current insurance if determined eligible for FHP.[12] However, if an individual has *employer-based* insurance when she applies for FHP (other than COBRA), her application will be denied even if she intends to drop the insurance. Since the state revised this policy in August 2002, there has still been confusion in the field, with facilitated enrollers, Medicaid workers and FHP managed care plans improperly demanding that applicants drop their private coverage before they apply.

7. **Other eligibility criteria**. FHP enrollees must have a photo ID. There are no finger-imaging or drug and alcohol screening requirements.[13]

III. Service Coverage for FHP

ALL FHP enrollees must enroll in a FHP managed care plan. All services, including pharmacy and family planning, are provided through the plan. This is in contrast to other Medicaid managed care plans with carve-outs for pharmacy and family planning outside the managed care network. The FHP benefit package resembles that commonly offered in the private insurance market and is less expansive than Medicaid. FHP enrollees receive primary, preventive, specialty and inpatient care, prescription coverage, emergency transportation, eye care, prosthetic and orthotic services, hearing aids, and durable medical equipment. In a law signed on September 17, 2002, hospice care was added to the FHP benefit package.[14]

Certain FHP services are covered but limited. Home health care includes a maximum of 40 visits per year and only in lieu of a skilled nursing facility or hospital stay. Nursing home stays are covered only for short-term rehabilitation, commonly understood as 30 days or less. Mental health and alcohol and substance abuse services are covered up to a *combined* maximum of 60 outpatient visits annually and 30 inpatient days annually, with more days allowed for inpatient detoxification. Only 20 visits per year for physical and occupational therapy are covered.

Services not covered by FHP include long-term nursing home stays, personal care services, home health care services for more than 40 visits per year, non-emergency transportation (e.g., ambulette service), adult day care, orthodontia, non-prescription medications and medical supplies other than for diabetic care, and dental care, which is optional for FHP plans. Nor are intermediate-care facilities for developmentally disabled and private duty nursing covered. Given these limitations, many persons with extensive medical or long-term care needs will need to opt for Medicaid with a spend-down instead of FHP.

There is **no cost sharing** permitted in FHP plans (i.e., no co-pays or co-insurance).

IV. Obtaining FHP

New applicants. People can apply for FHP in three ways—at their local Medicaid office, with a community-based facilitated enroller (non-profit agencies that contract with the state Department of Health) or directly with an FHP managed care plan.[15] One uniform "Access New York" application is used for the various programs—Medicaid, FHP, and Child Health Plus for children.[16] The enroller submits the completed application which must be processed by the local Medicaid office within a certain number of days from the application date—30 days for households with pregnant women and/or children and 45 days for all others.

Selecting the Best Coverage or Phased-In Coverage. As stated above, some applicants may have a choice between Medicaid with a spend-down or FHP. Which coverage they select will depend on their individual medical needs. Section G of the application elicits information that should help the enroller and the Medicaid office select the best coverage.[17] For example, the application asks whether anyone in the household has a disability; is handicapped, blind, or has a chronic illness. A "yes" answer to that question should provoke a discussion about whether the applicant may need the more extensive long-term care or other services covered solely by the Medicaid program and not by FHP.

Similarly, the application asks whether anyone in the household incurred or paid for medical expenses in the three months prior to application. Unlike Medicaid, in FHP there is no retroactive reimbursement for bills paid in the three months prior to application, and no coverage of unpaid bills incurred in the three-month pre-application period or while the application is pending. For persons who apply with unpaid medical bills, which may be substantial, or who recently paid for medical care for which they may be entitled to Medicaid reimbursement, it is imperative that the enroller and Medicaid agency authorize Medicaid at least for the three-month retroactive period and during the period of application.

While this phased-in coverage should be possible, there are challenges to making this system work. Part of the problem is inadequate training of enrollment workers in the complex rules of Medicaid reimbursement and eligibility, but part of the problem is in computer systems and procedures. Armed with examples of people who have already been wrongly denied Medicaid coverage for substantial medical bills, NYFAHC and other advocates are urging the state and local Medicaid programs to ensure that applicants be given Medicaid retroactively where warranted, with FHP coverage beginning prospectively, with a seamless transition between the two types of insurance. Applicants who are steered solely to FHP without at least a closed period of Medicaid authorization to cover past-incurred medical bills will have a strong legal challenge for violation of their rights under federal and state Medicaid laws and regulations.

Delays in Coverage. Even for those who apply without the burden of unpaid medical bills, anyone who needs medical care quickly will not be able to obtain coverage. The experience-to-date of many enrollers and managed care plans is that it takes two to six months to enroll in an FHP plan. Presently, there is no relief for these individuals. Those who may be eligible for Medicaid with a spend-down

during this application period should be able to receive Medicaid at least temporarily. But those who are not eligible for Medicaid at all have no recourse. Better procedures must be initiated to speed enrollment.

Terms of Enrollment in FHP. Applicants join an FHP managed care plan for a 12-month period, with the right to switch plans without cause for the first 90 days. An enrollee may change plans for good cause during the next nine months. There is no requirement that all family members must join the same FHP plan. Individuals are guaranteed an initial six months of coverage even if their income increases during that period by an amount that would render them ineligible for FHP. (Enrollees have a duty to report if their circumstances change.) A "seamless" transition from FHP to Medicaid should occur for individuals whose earnings dip.[18]

Newborns. Any baby born to a woman who is enrolled in FHP will be provided one year of automatic Medicaid coverage.[19] The baby will either be placed in the mother's FHP managed care plan or, if that plan does not participate in Medicaid, in the Medicaid managed care plan of the mother's choice. If there is no Medicaid managed care plan in the mother's district, the baby will enroll in fee-for-service Medicaid.

Recertification. FHP uses an annual mail-in recertification and does not require a personal interview.[20]

* * *

The author would like to thank the following organizations for information provided in this article. Both organizations can be contacted for further information.

The Legal Aid Society, Health Law Unit, 199 Water Street, New York, NY 10038. Health Hotline: (212) 577-3575, Upstate Health Hotline: 1 (888) 500-2455.

New Yorkers for Accessible Health Coverage (NYFAHC), The Tisch Building, 119 W. 24th St., 9th fl. New York, NY 10011-1913. Telephone number: (212) 367-1240. E-mail: nyfahc@gmhc.org (contact to obtain copies of publication, "Road Map to the Family Health Plus Benefit Package").

Endnotes

1. *See* N.Y. Soc. Serv. L. § 369-ee; N.Y. State Dep't of Health, "Eligibility Requirements for the Family Health Plus Program . . ." 01 OMM/ADM-6 (Nov. 2, 2001).
2. 2000 N.Y. Laws, ch. 419, § 38.
3. A summary of New York's Section 1115 waiver request is posted at http://www.health.state.ny.us/nysdoh/fhplus/summary.htm.
4. Data conveyed by N.Y. State Dep't of Health at meeting in September 2002, as reported by Elisabeth Benjamin, Supervising Attorney, The Legal Aid Society Health Law Unit.
5. Benefit tables with various household compositions are posted at http://www.health.state.ny.us/nysdoh/fhplus/who_can_join.htm.
6. 01 OMM/ADM-6 at 14.
7. Medicaid allows an applicant to apply an old but still viable hospital or other medical bill against the spend-down amount indefinitely. *See* 42 C.F.R. § 435.831, 96-ADM-15. A bill need only be incurred, not actually paid, to be credited against the spend-down amount. 42 U.S.C. § 1396a(a)(17), 42 C.F.R. § 435.831(d), N.Y. Comp. Codes R. & Regs., tit. 18, § 360-4.8(c) (N.Y.C.R.R.). A bill actually paid within the three-month pre-application period may be credited against the spend-down for up to six months. *Id.*
8. 01 OMM/ADM-6 at 10-11.
9. *Aliessa v. Novello*, 96 N.Y.2d 418, 730 N.Y.S.2d 1 (2001); GIS 01 MA/033 (Oct. 2, 2001).
10. 01 OM/ADM-6 Attachment IX.
11. In addition to facing the obvious financial and health risks resulting from having no health insurance, individuals who lose health insurance for more than 60 days risk having a pre-existing illness condition imposed for as much as twelve months on their future coverage. N. Y. Ins. L. § 3232.
12. N.Y. State Dep't of Health 02 OMM/INF-02 (Aug. 22, 2002).
13. *See* 01 OMM/ADM-6 at 9; *but see id.* at 13.
14. 2002 N.Y. Laws, ch. 526, eff. Sept. 17, 2002, amending N. Y. Soc. Serv. L. § 369-ee(1)(e)(xiv-xv) and Pub. Health Law § 2510(7)(a)
15. A list of FHP plans covering each county in New York State is posted online at http://www.health.state.ny.us/nysdoh/fhplus/how_do_i_choose_a_health_plan.htm.
16. The application with instructions is available online at http://www.health.state.ny.us/nysdoh/fhplus/application.htm.
17. *See* http://www.health.state.ny.us/nysdoh/fhplus/pdf/4220.pdf at p. 3.
18. *See* 01 OMM/ADM-6 at 22-24.
19. N.Y. Soc. Serv. L. §366(4)(1); 01 OMM/ADM-6 at 19.
20. N.Y. State Dep't of Health, "Recertification (Renewal) Procedures for the Family Health Plus Program (02 OMM/ADM-5, July 25, 2002).

Valerie Bogart has been a senior attorney with Legal Services for the Elderly in New York City since 1990, specializing in litigation, training and policy in Medicaid and access to long-term care services. Since 1997, with a grant from the New York Foundation, she founded and has directed on a part-time basis The Home Care Project at the Center for Disability Advocacy Rights (CeDAR), a nonprofit organization established in part to do class actions prohibited by federal restrictions on legal services offices. She is a graduate of NYU School of Law.

Elder Care News

Demystifying the Patient Review Instrument

By Barbara Wolford

Many of our clients hoped that it would never occur, they may have promised their loved one it would never happen—but nursing home placement has become necessary. The mere thought of placement may conjure images of facilities of long ago, where the elderly and mentally ill were warehoused in understaffed and unregulated nursing homes. Many believed that the patients were over-medicated, restrained and had no voice in their care. Consumer advocacy, federal reform and public lobbying have helped to transform the nursing home industry, to refocus their policies, procedures and responsibilities to enhance the quality of life of the aging population. Patients are now referred to as "residents"; restraint-free and least-restrictive environments were mandated; quality assurance, the Resident Bill of Rights, and anti-discrimination policies were developed. Family and resident coordination of care through multi-care family meetings, resident and family councils were established to assure quality of care, dignity and respect for all residents.

My experiences have indicated that in most circumstances our clients are placed in long term care facilities after a traumatic event. The family decision has been made because their loved one is now hospitalized, the need for a higher level of care has been incremental with declining health, or infrequently the choice may be voluntary after long-range planning.

As professionals, we often find that we need to assist our clients in accessing and obtaining placement in an appropriate facility. Many clients assume that the only criteria for admission is ability to pay and are astounded to discover that their loved one requires medical approval for admission. Frequently medical approval becomes a larger challenge for our clients, due to dementia, history of unsafe behavior, costs of medicine, types of medical interventions or equipment, diseases or lack of necessity for "skilled care," therefore deemed "custodial."

The Patient Review Instrument (PRI) is the medical evaluation tool that identifies if a person is eligible for long term care placement. In addition a Patient Screening Instrument (a "Screen") is required. The PRI and Screen are tools used to determine the level of care and appropriateness of placement, and ultimately will factor into the reimbursement the facility will receive for providing that care. Basically, the rule of thumb is: the more care or complexity of care that the client requires, the higher reimbursement the nursing home will receive. The eight-page form is completed by certified trained evaluators, usually nurses. If the client is in a hospital setting, the hospital staff will perform the evaluation. If your client resides in the community, you will need to assist the family with arranging to have an independent evaluator assess the client and prepare the PRI and Screen. Geriatric care managers, home health care agencies, senior assessment programs and nurses are excellent sources to utilize. I have been able to establish collaborative relationships with evaluators, which has enhanced the firm's ability to provide a continuum of services to our clients. A community-based PRI is valid for 90 days; if the location of the client changes due to hospitalization, an assessment will need to be done from that location.

The Screen validates that the individual qualifies for long term care placement and that community-based services or a lower level of placement is not, or is no longer, appropriate. The Screen also identifies individuals who have mental illnesses, mental retardation or psychiatric histories. If these conditions exist, further assessment is required to assure appropriate placement. It is not used to document Alzheimer or dementia-type illnesses.

The PRI and information documented on this form can open or close doors to nursing facilities and is a crucial component used by the professional advocating and facilitating nursing home placement. Therefore, it is imperative that we understand what the PRI assesses and how the nursing home staff will evaluate the client for admission. There may be barriers that hamper our ability for successful placement that are beyond our control, such as lack of bed availability especially if the client suffers from dementia or has a medical condition that requires complex nursing care. Another obstacle in placement is that many nursing homes are accepting a majority of short term rehabilitation or sub-acute residents, which places the long term client at a disadvantage, with frequently a longer waiting period to secure a bed. In advocating for our clients, it is essential to be cognizant that the nursing facility staff cannot dis-

criminate on the basis of race, religion, color, national origin, gender, handicap, disability, source of sponsorship, source of payment, marital status, age or sexual preference in the admission, retention or care of residents.

Since nursing home placement is based on the PRI and Screen it is essential that, as professionals who counsel clients, we remain educated and familiar with the process of how the PRI is completed and how to interpret this evaluation tool. It should also be noted that family involvement should be strongly encouraged. Our clients can act socially appropriate, mentally intact or on a good day present a level of independence that may skew the PRI evaluation. Be aware that the evaluator most likely is meeting your client for the first time and the caregiver is key to verifying and attesting to the needs of their loved one. We may also need to recommend that the client be evaluated by PRI assessors that have expertise with specific diseases, disabilities or conditions that position the PRI to reflect a realistic portrait of the individual. Medical records should be evaluated; changes in behaviors, frequent falls, and recent medical events should be documented. A written summary or synopsis of the evaluator's observations and findings can be helpful to further enhance and support the PRI.

The PRI determines the level of care and staff time necessary to appropriately care for the resident by documenting three indicators. These indicators are:

A CATEGORY which defines a specific medical condition, medical treatment or if the client is physically and/or verbally aggressive or assaultive.

A numerical and letter SCORE that reflects how much assistance, independence or supervision the resident requires in toileting, eating, and transferring which is translated into a letter between A-E (with A-B indicating a more independent individual and C-E a person requiring more dependent and higher level of care).

A RESOURCE UTILIZATION GROUP (RUG) is attained by combining the category and ADL score.

The final PRI consists of a numerical score for activities of daily living (ADL) and one of five health categories which then determines the RUG.

The client's level of independence is assessed in three areas of daily living—a score is given for each of these functions and added together to obtain a numerical tally of between 3 and 10. This score is based on how the individual was able to perform these tasks 60 percent of the time during the previous four weeks prior to evaluation or since admission to the hospital. An individual with a lower score is more independent than the client with a higher score.

The three areas that are evaluated and scored are:

EATING: considers how the individual consumes food, maintains nutrition, level of independence, the need for verbal cuing, assistance with opening containers, or cutting food. The client is observed to determine if he or she requires total assistance so that the meal will be consumed, or if totally fed by a staff member or nourishment by parental or tube feeding is documented.

"Since nursing home placement is based on the PRI and Screen it is essential that, as professionals who counsel clients, we remain educated and familiar with the process of how the PRI is completed and how to interpret this evaluation tool."

TRANSFERS: defined as the act of moving between positions, to/from bed or standing. The individual is evaluated to determine if physical assistance is required or if transfers are independent. The person may only require intermittent supervision or assistance with a single aid, guidance, safety, steadiness, or if physical assistance may be provided on a continual basis. The totally dependent person requires two people to lift and transfer, or perhaps medical equipment such as a lift to facilitate transfers if the person is entirely bed-bound.

TOILETING: described as the ability to get to and from a toilet, bedpan or commode, ability to transfer on/off toilet, maintain personal hygiene and appropriately adjust clothing. The evaluator is assessing if the person is continent or incontinent, requires assistance or supervision in toileting activities, is not taken to the bathroom and is diapered or perhaps is incontinent but on a toileting and bowel regime.

Once the ADL is tallied, the individual is assigned one of five special-needs groups, depending on the score and medical condition:

HEAVY REHABILITATION: this qualifier is defined as an individual who requires restorative physical or occupational therapy with the prognosis of improvement. The therapy must be five times per week for at least 2½ hours per week.

SPECIAL CARE: does not meet the above criteria and has an ADL score of 5 or more and presents with one or more of the following: stage 4 decubitus, comatose, suctioning, nasal gastric feeding, parental feeding, quadriplegia or multiple sclerosis.

CLINICALLY COMPLEX: does not qualify for either of the above categories and the individual's ADL score is less than 5 with one of medical condition delineated in the Special Care category OR does not meet the criteria for Special Care and may have one or more of the following conditions: dehydration, internal bleeding, stasis ulcer, daily oxygen, terminal illness, wound care, chemotherapy, blood transfusions, dialysis, urinary tract infection, one or more MD visits per week, or cerebral palsy.

SEVERE BEHAVIORAL: does not meet the criteria for Clinically Complex and exhibits either verbally, disruptive infantile, socially inappropriate, disruptive or physically aggressive behavior. This behavior must be documented to have occurred one time per week during the past four weeks.

REDUCED PHYSICAL FUNCTIONING: The individual is classified in this group if he or she does not meet the criteria for any of the previous groups. Generally, this is the custodial client who presents a challenge for appropriate placement.

Once all of the scores and groups have been identified, the RUG (Resource Utilization Group) is determined.

Finally, we have the PRI—what is the next step in the process? The PRI is now scrutinized by the nursing home staff, perhaps an admissions screening team, the Director of Nursing Services, the physical and occupational therapist, or even the Medical Director. In some circumstances, the nursing home may require that the client be evaluated by a member of the nursing home staff to assure that the PRI is correct. If the client resides in the community, additional medical information (i.e., chest x-rays, blood work, proof that the client is free from communicable diseases) may be required.

What is documented on the PRI can be difficult to reverse. As previously stated, often the evaluator is interviewing the client for the first time. Due to time constraints this interview may be of short duration with the emphasis on the medical notes in the patient's chart. Timing of the PRI is critical for an accurate portrayal of the hospitalized patient. Frequently, medical conditions can significantly alter the physical and mental status of the individual. Usually, for a number of reasons, the hospital staff is looking to expedite discharge and the family is pressured to accept a nursing facility bed that is not conveniently located or may not have the appropriate level of care the client requires.

I find in advocating for our clients it is beneficial to contact the hospital discharge planner or case manager immediately to introduce myself and advise that our firm has been retained to assist the client in facilitating the discharge. (I have the client sign a medical agent authorization that allows me to discuss and obtain medical information.) I request that the PRI be provided to me so that I can review the PRI with the family to validate the information and determine what facility may be appropriate for the client. I meet with the family to discuss the PRI and also to discuss what long term care facilities would be appropriate and suggest that they contact the facility to arrange a tour and obtain the admission paperwork. After this conference, I contact the nursing home admissions staff as soon as it has been determined that the family has indicated an interest in that particular facility. I advise that I will be assisting the family with the placement process, will forward the PRI for their review and will complete the financial portion of the application. During the process I keep in constant communication with the family, hospital and nursing home staff. After placement is secured, I follow up with the nursing home and family to assure that placement has gone smoothly and offer to provide further assistance as necessary.

In conclusion, familiarizing and enlightening ourselves with all aspects of the discharge process can only further enhance our ability to advocate for our clients and their families in securing placement that will afford them the dignity, respect and the quality of care that they deserve.

Barbara Wolford is the Director of Elder Care Services for the Elder Law and Estate Planning firm of Davidow, Davidow, Siegel & Stern. She has been associated with the firm since 1996. Ms. Wolford is a Licensed Practical Nurse who concentrates in assisting families with the complex Medicaid process as well as the assessment procedure necessary for evaluating families' needs. Her background as a former Nursing Home Admissions Director lends itself well to her current position.

In addition, she is very active in senior organizations and advocacy by serving as the co-director of the Council for the Suffolk Senior Umbrella Network, a board member of the New York State Coalition for the Aging, a member of the Long Island Coalition for the Aging, a member of the American Association on Aging, Nassau and Suffolk Geriatric Professionals of Long Island and Case Management Society of America.

Bonus News 1

Connecticut Waiver Proposal

By Daniel G. Fish

The Connecticut Department of Social Services (DSS) is seeking to radically alter long-standing federal Medicaid eligibility rules. It proposes to change the date upon which the penalty period begins to run. It also proposes to extend the look-back period for transfers of real estate. If implemented, these changes would adversely affect the validity of planning already implemented. Seniors would be denied needed medical coverage for transfers that were sanctioned at the time they were made.

Federal law establishes the eligibility rules for the Medicaid program. In particular, federal law creates the date upon which the penalty period starts to run and the look-back period for transfers of real estate. Connecticut DSS is not seeking to make these changes through an amendment to the Medicaid statute. It is seeking to implement the changes through an inappropriate use of the waiver provision.

"Connecticut DSS is requesting authority to subject real estate transfers to a 60-month look-back period."

Section 1115 Waiver

Connecticut has asked for a waiver of Medicaid eligibility rules under the authority of section 1115 of the Social Security Act (42 U.S.C. section 1315a). That provision provides:

> In the case of any experimental, pilot, or demonstration project which, in the judgment of the Secretary, is likely to assist in promoting the objectives of subchapter . . . XIX of this chapter . . . the Secretary may waive compliance with any of the requirements of section . . . 1396a of this title, as the case may be, to the extent and for the period he finds necessary to enable such State or States to carry out such project.

Medicaid: A Means-Tested Program

Eligibility for Medicaid is based upon financial need. There are savings and income levels above which an individual will be denied approval for benefits. The agency also looks beyond the current savings and income. The agency makes an investigation of past financial activity. Certain financial transactions will disqualify an applicant.

The Look-Back Period

When an applicant applies for Medicaid benefits, the agency reviews financial information going back 36 months from the date of application. There is one exception: if the applicant has transferred assets to an irrevocable trust, the agency may review the financial information about that trust going back 60 months from the date of application.

Under current federal law, real estate transfers are subject to a 36-month look-back period. Connecticut DSS is requesting authority to subject real estate transfers to a 60-month look-back period. If an applicant transferred his or her home 37 months ago, under current rules the property would not be considered. If the waiver were granted, Connecticut DSS would be allowed to consider that transfer in its calculation of eligibility.

The Penalty Period

If the agency detects a transfer for less than fair market value within the look-back period it must apply a formula to determine whether the transfer will result in a denial of benefits. The formula divides the amount transferred by the average cost of one month in a nursing home. The resulting number is the number of months of Medicaid ineligibility. By current federal law the disqualification period starts to run with the month that the transfer is made.

Connecticut DSS is seeking, by its proposed waiver request, to delay the initiation of the running of the penalty period. Connecticut wants to start the running of the penalty period when the Medicaid application is filed.

The average monthly cost of nursing home care in Connecticut is $6,779. Under current rules, if an applicant transferred $67,790 ten months ago and applied today, the penalty period would have

expired. If the waiver were granted, the applicant would not be eligible for ten months from today.

Not all transfers within the look-back period result in disqualification. Transfers between spouses are not subject to disqualification. Neither are transfers to minor blind or disabled children. Transfers of homesteads to caretaker children or siblings with an equity interest are also protected. The waiver request makes it clear that these protected transfers would not be affected.

The Secretary of the Department of Health and Human Services under section 1115 is authorized to waive compliance only with the requirements of section 42 U.S.C. section 1396a. The starting date of the penalty period and the length of the look-back period for real estate are found in 42 U.S.C. 1396p. While the Secretary may enjoy wide discretion in this area and the courts may give great deference to administrative agencies, it would be a clear abuse of discretion to grant a waiver outside of 42 U.S.C. section 1396a.[1]

The fundamental reason that section 1115 waivers are permitted was to allow the states to expand services through experimental, pilot or demonstration projects. The Connecticut waiver request is simply a stratagem to save funds. This artifice was rejected in *Beno v. Shalala*.[2]

The status of the waiver is pending before CMS (Center for Medicare and Medicaid Services), a division of the Department of Health and Human Services. The waiver has profound implications for New York State. If it is granted, Connecticut residents may seek Medicaid in New York to avoid the harsh penalties. In addition, other states may seek the same waiver.

Endnotes

1. *See Pharmaceutical Research and Manufacturers of America v. Thompson*,251 F.3d 219 (D.C. Cir. 2001).
2. 30 F.3d 1057 (9th Cir. 1994).

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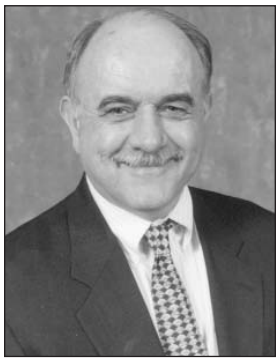
Bonus News 2

Medicaid Chronic Care Budgeting and Child Support

By Gary W. Johnson



In *Lanzi v. Lanzi*,[1] the Second Department reviewed a Family Court decision where a community spouse with minor children was awarded child support pursuant to Family Court Act section 413 (FCA). In the thoughtful and well-reasoned opinion of Justice Myriam J. Altman, in which the full panel concurred, the Second Department held that the guidelines pursuant to the CSSA, FCA section 413, *should* be followed and that the budgeting methods as provided for in Social Services Law section 366-c (SSL), specifically the family allowance provisions, *did not apply* to child support. The Appellate Division did, however, hold that trial courts should consider the state interest (i.e. Medicaid) along with all other relevant factors pursuant to the CSSA.

The institutionalized spouse, a relatively young man, had been a nursing home patient for several years. His income consisted of a substantial pension from his former employer and also Social Security disability benefits.

Prior to the institution of the Family Court proceeding, the local agency (the New York City Department of Social Services (DSS)) had allowed the Petitioner an amount to raise her monthly income to the minimum monthly needs allowance and an additional amount pursuant to the formula "family member allowance."

In July 2000, the community spouse commenced a proceeding in Family Court, Richmond County seeking an award of spousal support (limited to the Community Spouse Monthly Income Allowance) and child support for basic child support, educational expenses and unreimbursed medical expenses as provided for in FCA section 413. Respondent New York City DSS argued that expenses for child support were fully covered by the family allowance as set forth in SSL section 366-c and argued against an award pursuant to FCA section 413.

The hearing examiner held that he need not consider the provisions of SSL section 366-c and made an award of basic child support of $785 per month, 77 percent of the children's educational expense ($452 per month) and 77 percent of the unreimbursed medical expenses.

The New York City DSS filed objections. The decision of the hearing examiner was affirmed by the Family Court and the DSS appealed.

In distinguishing the family allowance of SSL section 366-c from the child support obligation of FCA section 413, the court noted that the family allowance is applicable to dependent or minor children and also other family members and that the family allowance cannot be equated with the child support obligation which FCA section 413 (1)(a) imposes upon "parents of a child under the age of twenty-one years."[2]

In reviewing the provisions of FCA section 413, the court noted that the trial court may deviate from the numerical guidelines based upon a finding that awarding a strict *pro rata* share of basic child support might be unjust and inappropriate. The court also noted that a parent's medical expense is not one of the factors specified in FCA section 413 (1) as a specific factor to be considered, but that there was a "catch-all" provision, authorizing the Family Court to consider "any other factors."[3]

The court compared the holding in *Gomprecht v. Gomprecht*,[4] for spousal support and an application for child support.

The court distinguished the issues in *Gomprecht* from the instant case by pointing out that pursuant to FCA section 412, with respect to spousal support, a spouse "may" be required to pay spousal support, but noted that FCA section 413, with respect to child support, contains the mandatory language "shall" with respect to the child support obligation of the non-custodial parent.

The court noted that the Respondent possesses the means to satisfy some but not all of his obligations and that the dilemma in cases such as this is how to reconcile those conflicting obligations.

The court, in further commenting on the conflicting statutes, noted that SSL section 366-c had the limited purpose "to alleviate true financial hardship that is thrust upon the community spouse,"[5] and that, in contrast, FCA section 413 is founded upon "the parental obligation to provide for a child and for a child's education."[6]

The court favorably cited *Cuthbert S. v. Linda S.*,[7] where the Family Court awarded basic child support pursuant to the numerical guidelines, but limited the expense for private high school and held that "in the instant case the Family Court must consider the requirements of FCA section 413 in conjunction with Social Service Law section 366-c and weigh competing State interests and all relevant factors."[8]

The matter was remanded to the Family Court for a new determination consistent with the decision. As of this writing, the hearing on remand in Family Court has not been held.

In summary, a fair interpretation of the decision is that in applications for child support by a community spouse:

- The guidelines of the CSSA as set forth in FCA section 413 and Domestic Relations Law section 240 will control.
- The fact that Medicaid benefits are being paid on behalf of the institutionalized spouse/respondent will have to be considered by the trial court, perhaps as an FCA section 413(1)(f)(10) "catch all" factor.
- The portion of child support determined by applying the numerical guidelines to the parental income and the portion of child support for medical expenses appears to be protected from diminution on account of Medicaid.
- The portion of child support for post-secondary, private, special or enriched education is subject to possible challenge, perhaps because the FCA states that the court "may" award such educational expenses.

PRACTICE NOTE: When making an application for child support, practitioners may consider also making an application for spousal support. Pursuant to the constraints imposed by the holding in *Gomprecht*, the awards for spousal support will be limited to the amount allowable under the Community Spouse Income Allowance, but the community spouse would have the benefit of a court order as opposed to a budget allowance. In cases when the income of the community spouse subsequently increased, it would appear that his or her allowance could not be administratively reduced but that the local agency would be required to commence an action for downward modification of the court-ordered support.

Endnotes

1. 747 N.Y.S.2d 50 (2d Dep't 2002).
2. *Id.* at 53.
3. FCA § 413 (1)(f)(10).
4. 86 N.Y.2d 47, 52, 629 N.Y.S.2d 190, 652 N.E.2d 936 (1995).
5. Citing *Schachner v. Perales*, 85 N.Y.2d 316, 324 n.3, 624 N.Y.S.2d 558, 648 N.E.2d 1321 (1995).
6. *Id.* at 324, 325.
7. 161 Misc. 2d 372, 613 N.Y.S.2d 801 (Fam. Ct., Kings Co. 1994).
8. *Lanzi v. Lanzi, supra,* at 55.

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